The IPRO Hospital Quality Improvement Contract

Reducing Readmissions with Patient and Family Advisory Councils or Patient and Family Advisors

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Introduction to the AIR Team

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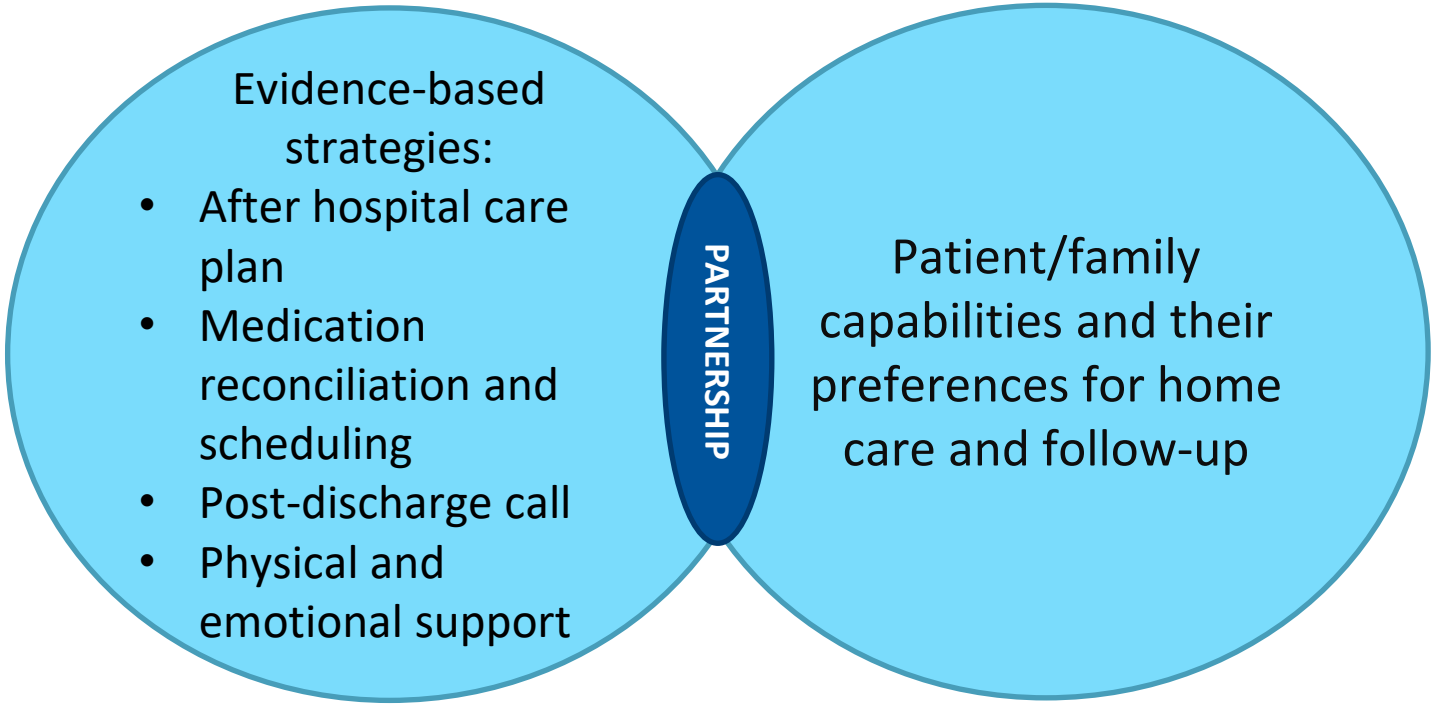
Learning Objectives

- Understand how patient and family members can assist hospitals in reducing unplanned hospital readmissions
- Apply approaches to engaging Patient and Family Advisory Councils (or Patient and Family Advisors on hospital committees) to reduce unplanned readmissions
- Discuss ways that PFACs and Patient and Family Advisors in HQIC hospitals contribute to hospital-wide efforts to reduce unplanned readmissions

Partnering with Patients to Reduce Unplanned Readmissions

How do these evidence-based strategies make life better for the patient and family? The community?

How do they make life more difficult?



What is preventing patients from following evidence-based strategies?

What is needed in the home or community to improve outcomes?

Partnership: Adapting problem-solving strategies to fit patent/family needs and preferences, resulting in agreement and commitment

Interventions to Improve Hospital Readmissions

- Clear, monitored discharge procedures can reduce the risk of readmission
- Interventions starting during the hospital stay and continuing after discharge were more effective in reducing readmissions compared to interventions starting after discharge
- Enhancing patient empowerment is a key factor in reducing hospital readmissions

A study of 110 hospitals in New York found that hospitals with a PFAC performed better than hospitals without a PFAC on:

- pressure ulcers,
- sepsis and septic shock, and
- 30-day hospital-wide readmissions

Source: IPFCC (June 2018). *Strategically Advancing Patient and Family Advisory Councils in New York State Hospitals.* Funded by the NYS Health Foundation.

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Readmission Drivers: The Provider Perspective

- Pressure to discharge quickly
- Lack of clarity regarding who is responsible
- Patients' family pushes for discharge
- Communication issues in coordinated plan for post-discharge care
- Concern that patients are not always honest in self-assessments
- Patients may not have the means to meet their basic needs

Readmission Drivers: The Patient Perspective

- May feel that they were discharged too soon
- Many did not understand their discharge instructions because they were too general
- Patients and caregivers not assertive enough
- New diagnoses pose special challenges
- Primary care physicians are missing from the picture
- Limited or no support once home
- Some were not ready to change behaviors
- Lack of education about their illnesses
- Confusion about follow-up care

Inconsistencies Between Perspectives

- There is also a concern about imposing a negative value on readmission and assigning blame
- A recent study demonstrated that providers were more likely to identify patient factors as contributing to readmission, whereas patients were more likely to identify system factors; for example, the need for earlier follow-up with a doctor
- Nurse case managers evaluated each readmission case and, in alignment with patient perspectives, identified system factors most of the time

Soliciting the Patient and Family Perspective

About readmission

- In your mind, what was missing for you to recover successfully at home?
- What resources were not available to you that might have helped you be successful?

About the discharge process

- How confident did you feel after your discharge from the hospital that you could recover successfully at home?
- What do you wish you had been told or been provided that would have helped you after your discharge?
- What could the hospital do differently at discharge to make your recovery at home successful?

What Can a PFAC Do to Help Reduce Unplanned Readmissions?

- Share the patient/family perspective about the discharge process and readmission experience
- Co-create patient/family education materials
- Help design/revise the discharge process
- Create an empowerment campaign for patients and families to increase self-management post-discharge
- Work in the community to fill resource gaps that keep people from successful home recovery
- Assist in follow-up calls or visits with discharged patients to learn more about their needs or offer support

Getting Started

- **Identify** who at your hospital is best to work with the PFAC or Patient/Family Advisors on the issue of unplanned readmissions
  - Prepare this individual if they are unfamiliar with working with patient and family advisors
- **Inform** the PFAC or Patient/Family Advisors about readmissions trends at your hospital
- **Engage** the PFAC or Patient/Family Advisors in a root cause analysis of unplanned readmissions at your hospital
  - Be ready – Patient Advisors may identify very different root causes! Encourage active listening and avoid defensiveness
  - Solicit ideas and suggestions from the PFAC or Patient/Family Advisors on how root causes could be addressed
- **Ask** the PFAC how they would like to contribute to improving readmissions at your hospital

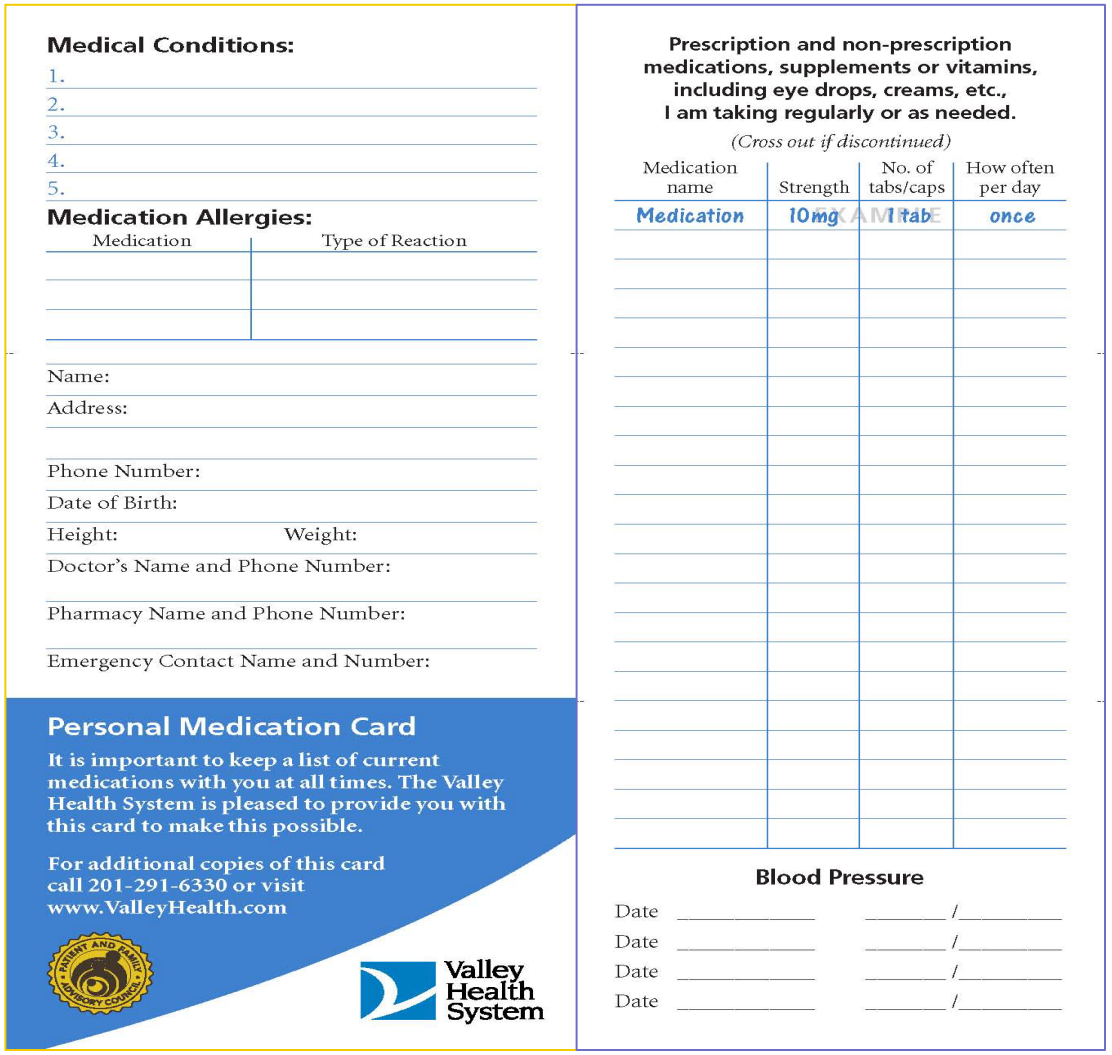
Example: Astera Health, Minnesota

- Struggled in medication management and including the patients in healthcare decisions
- Brought questions from patient experience survey on these topics to the PFAC committee and asked them why they thought we struggled with these questions through in-depth conversations
- “All of them felt that we do a good job reviewing medications and the management of them as well as they felt we include them in decisions”
- “Together we concluded it could be how we spoke about it and plan to use more narrative care and emphasize key words to help the recall of this information”
- Currently working on scripting discussions around medications and to monitor patient experience data after implementation

Example: Valley Health System, New Jersey

- PFAC focused on medication administration and reconciliation
  - PFAC was part of the approval process to assist in standardization
- Buttons for nurses – “let’s talk about medication”
- Medication card - reviewed and customized based on PFAC input
  - Medication cards and a medication list is now sent to all patients after they are admitted to home care
- Outcomes: increase in HCAHPS scores in 2017
  - Talk about taking medicine went from 92.7 to 95.2
  - Ask to see all meds patient is taking went from 82.6 to 89.0

Example: Valley Health System, New Jersey



Medical Conditions:

1.
2.
3.
4.
5.

Medication Allergies:

Medication	Type of Reaction

Name:
Address:

Phone Number:
Date of Birth:
Height: Weight:
Doctor's Name and Phone Number:

Pharmacy Name and Phone Number:

Emergency Contact Name and Number:

Personal Medication Card

It is important to keep a list of current medications with you at all times. The Valley Health System is pleased to provide you with this card to make this possible.

For additional copies of this card call 201-291-6330 or visit www.ValleyHealth.com

Valley Health System

Prescription and non-prescription medications, supplements or vitamins, including eye drops, creams, etc., I am taking regularly or as needed.

(Cross out if discontinued)

Medication name	Strength	No. of tabs/caps	How often per day
Medication	10mg	1 tab	once

Blood Pressure

Date _____ _____/_____
Date _____ _____/_____
Date _____ _____/_____
Date _____ _____/_____

Valley Health PFAs:

- Shadowed the home care staff doing medication review in initial home visits with patients and families and discovered inconsistencies in practice
- To support reliability, the discharge materials were revised

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Example: Kingston Health Sciences Centre, Ontario

- Field tested phone call follow-ups after discharges with patients and family advisors and reached out to specific organizations in the community
- Phone call follow-ups started in September 2018:
  - 30-day readmission rate for these patients has decreased 22%
  - 7-day emergency department revisit rate has decreased 25%
- Quotes from patient calls
  - "I'm so glad you called, I have so many questions..."
  - "I was just heading to the emergency room because I didn't know what to do..."

Group Discussion

- How does your hospital invite patients and families to share their perspectives on the discharge process? On unplanned readmissions?
- How can your hospital partner with patients and families to help reduce unplanned hospital readmissions?

New Tool:

A Crosswalk to Focus the PFE Best Practices on All-Cause Harms

https://hqic-library.ipro.org/2023/04/04/connecting-pfe-best-practices-to-all-cause-harm-reduction/

Connecting the Five Practices to All-Cause Harms

	PFE Best Practice 1: Implementation of a planning checklist for patients who have a planned admission	PFE Best Practice 2: Implementation of a discharge planning checklist	PFE Best Practice 3: Conducting shift change huddles and bedside reporting with patients and families	PFE Best Practice 4: Designation of a PFE leader in the hospital	PFE Best Practice 5: Active Person and Family Engagement Committee or other committees
Unplanned Readmission	Discuss successful discharge as a goal of hospital care	Engage patient and designated care partner in planning for hospital discharge	Include discharge plans in daily conversations; connect activities of the previous and future nurse shift periods to planning for hospital discharge	Identify and recruit former patients or their family caregivers who have experienced unplanned readmissions to participate in efforts to address readmissions in the hospital	Invite and include patient and family perspectives and ideas for reducing unplanned readmissions in the hospital or department; partner with patient and family advisors to implement and evaluate efforts to reduce unplanned readmissions

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Questions?

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