Enhanced Assessment for Post Hospital Needs

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Session Objectives

Participants will be able to:

- Identify failures in current processes to assess post-discharge needs from the literature and participant experience
- Identify key improvements to enhance the assessment of a patient’s post-discharge needs
- Discuss strategies for getting started and collaborating with family caregivers and community-based partners
“….gain a deeper understanding of the comprehensive post-hospital needs of the patient through an ongoing dialogue with the patient, family caregivers, and community providers?”
Go Observe: “Be a patient”

- Identify a patient to observe on a particular unit
- Get permission from the patient to spend 1-2 hours observing assessment
  - On admission and during the stay, e.g. during multidisciplinary rounds
- Observe from the perspective of the patient and family caregivers
- What went well and what could be improved?
- Diagnostic tool in the IHI toolkit
Key Changes for Enhanced Assessment

Partner with patient and family to determine post-hospital needs:

- Involve the patient, their family, family caregiver(s) and community providers as full partners in completing a needs assessment of the patient’s home-going needs

- Reconcile medications upon admission

Partner with Patient and Family to Determine Post Hospital Needs

Typical Failures:

- Not addressing the whole patient
  - (e.g., focusing on one condition, missing underlying depression or social needs, etc.)

- Looking at only current admission missing the need to look at previous admissions in 30 - 90 days, 12 months

- Not addressing palliative care or end-of-life issues
  - Delayed or absent goals of care discussion
  - Missing advance directives or planning beyond Do Not Resuscitate (DNR) status

- Medication errors, polypharmacy, and incomplete medication reconciliation
Partner with Patient and Family to Determine Post Hospital Needs

Typical Failures continued:

- Labeling the patient as ‘noncompliant’
- Not recognizing the care team’s responsibility for facilitating self-care management
- Excluding the patient and family caregivers leading to poor understanding of the patient’s capacity to function in the home environment
- Not sharing what is learned with those in need of information-reliably
Partner with Patient and Family to Determine Post Hospital Needs

**Typical Failures** continued:

- Lack of probing around unrealistic patient and family caregivers' optimism to manage at home.
- Lack of understanding of the patient's functional ability, physical and cognitive status, and social and financial concerns, which results in transfer to a care setting that does not meet the patient's needs.
Partner with Patient and Family to Determine Post Hospital Needs

‘Enhanced assessment’ goes beyond the nursing admission assessment

- Start on Admission
- Establish a relationship – Sit down – be attentive – LISTEN
- Involve patient, their family caregiver(s) and community provider(s) as full partners
- Continue ongoing assessments throughout the hospital stay to reveal new need-to-know details
- Share what you learn with the care team
Involve Patient and Family Caregivers

- "Family caregivers" are those individuals who are directly involved in the patient’s care at home.
- "Visitors" are not necessarily the persons who best understand the home environment limitations/issues and the patient’s home-going needs.
Post-hospital Needs Assessment

- Cognitive, functional, and depression screening
- Care capacity of patient: clinical, motivation, ability
- Health literacy
- Willingness and ability of family caregivers
- Follow-up needs: primary and specialty care providers
- Home care needs
- Level of risk: high utilizers, homeless, substance abuse
- Financial assistance needs to meet care goals
- Community support needs
Assessments are Conversations

- Sit down and include family, caregiver(s)
- Ask open ended questions:
  - What do you think may have caused you to come to the hospital?
  - Did you call your health care provider (HCP) when you became concerned?
  - What prompted you to call or what kept you from calling?
  - When was your last appointment with your HCP?
  - Were you able to keep the appointment, if not, why not?
  - How do you take your medications at home?
  - Describe kind of foods you eat at home
  - When was the last time you were in the hospital?
  - Do you think there is anything that could have prevented coming to the hospital?
Assessments > Improving Discharge

- Communicate what is learned in the conversation
- Use learning to improve communication
- Hospital based team and community providers co-design communication content and processes
- Include useful information that might be beneficial but not found on a form, e.g.:
  - Useful medication lists
  - Ability and motivation to provide self care
  - Advance directives; Goals of Care conversation was started
  - Patient likes to take pills with ice cream
  - Patient very concerned about her dog, etc.
  - Patient aware that he is getting forgetful and concerned for future
S.M.A.R.T. Discharge Protocol

S.M.A.R.T. Discharge Protocol: a framework applied to our current discharge process to ensure that 5 key areas are *always* addressed during hospitalization and at discharge.

- **S**ymptoms
- **M**edications
- **A**ppointments
- **R**esults
- **T**alk
“Going Home” Plan

Going Home: What You Need to Know
How-to Guide resource page 96

http://www.nextstepincare.org/Caregiver_Home/Going_Home/

Example of a Bedside White Board
Whiteboards communicate daily goals, expected discharge date and discharge goals, and questions patient and family caregivers have for the care team.
Ongoing Assessment of Post-Hospital Needs

Transformational Change Ideas:
- Take 5 – establish a relationship and build trust
- Go Deeper
- Nurses and members of the care team think like an investigative reporter
  - Ask the “5 Whys”
  - Ask patient and family caregivers - “why do you think you needed to come to the hospital?”
  - Ask patient and family caregivers - “what are you most worried about when you go home or to the next care setting?”
“5 Whys” Root Cause Analysis

Problem: ______________

Clear problem statement

Why’s must hang together reading top to bottom and bottom to top

Last “Why?” must be clear, singular, and testable

Real solution is found here

Balik & Nielsen 2012
5 Whys Root Cause Analysis

Problem: Why wasn’t Mr. B taking his meds?

Why?

No $ for meds → Why?

No insurance → Why?

No application/Medicaid → Why?

Needs help with application → Why?

Unintended consequences of receiving Medicaid

Real solution is found here

5 Whys Root Cause Analysis

Problem: Mrs. A. returned to hospital in 5 days

Why? She gained 10 lbs in 4 days

Why? She didn’t comply with her discharge instructions

Why? She didn’t understand

Why? No Teach Back

Use of Teach Back not reliable

Collaborate and Standardize

- Standardize processes to ensure reliability
  - Who is assigned to following up if admitting can’t reach community providers? (Someone should be assigned)

- Reach out – e.g., home health nurses may have valuable information for providers

- Collaborate with skilled nursing facility teams to improve and ensure effective two-way communication
  - Interact tool – “Nursing Home to Hospital transfer form”
Involve Community Providers to Assess Post-Hospital Needs

What home-going needs or contributing causes for unplanned hospitalizations can we discover from community providers?

- Primary care providers and specialists
- Home health care nurses and staff
- Staff in skilled nursing facilities
- Rehabilitation centers
- Dialysis centers
- Pharmacies
- Church groups
- Palliative care or hospice programs
- Agencies on aging & other community-based services
Using Process Measures to Guide Your Learning

Percent of admissions where patients and family caregivers are included in identifying post-discharge needs.

Note: To determine whether patients and families were involved in discharge planning, you will need to define a process for staff to use.

Definition details on page 70 of the How-to Guide.
What Are We Learning About Completing an Enhanced Assessment?

- Most teams think that they are already doing this - yet gained new insights from completing the diagnostic reviews.
- Teams benefitted from embedding diagnostic review questions into admission assessment for patients and in their EMRs.
- Initial assessment should be completed upon admission; ongoing assessment of home-going needs should occur throughout hospitalization.

What Are We Learning About Completing an Enhanced Assessment?

- Family caregivers and community providers are a vitally important source of information about home-going needs of patients.
- It is very hard to know exactly which community providers to call for the best information, and it is time-consuming to track down these providers.
- Multidisciplinary rounds are important to build the patient- and-family-centered story and establish a comprehensive post-hospital plan of care.
What Are We Learning About Completing an Enhanced Assessment?

- There are often discrepancies between the patient’s, the family caregiver’s, and provider’s perceptions of the patient’s needs and capabilities.

- Completing a comprehensive admission assessment requires additional time:
  - Roles and responsibilities need to be designated.
  - Standard work processes need to be developed.
Table Exercise

- What is your experience with completing enhanced assessments to discover the patient’s perspective?
- What will your next steps/testing look like?
- Can you share either a patient story or a concern you might have?