Perform Enhanced Admission Assessment of Post-Hospital Needs

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These presenters have nothing to disclose.

Session Objectives

Participants will be able to:

- Provide an overview of this key change
- Discuss strategies for testing and implementing this key change
- Provide an introduction to action planning for this key change, including designing reliable processes as well as testing and using process measures

Perform an Enhanced Assessment of Post-Hospital Needs

- Most teams think that they are already doing this -- but have gained new insights from completing the Diagnostic Reviews
- Family caregivers and community providers are an important source of information about home-going needs of patients
- Completing a comprehensive assessment requires additional time (roles and responsibilities need to be designated and standard work processes need to be developed)
- Many are embedding questions from the Diagnostic Review into admission assessment for patients who have an unplanned admission to the hospital

Perform an Enhanced Admission Assessment for Post-Hospital Needs

Typical Failures

- Excluding the patient and family caregivers in assessing needs, identifying resources, and planning for discharge
  - Leads to poor understanding of the patient's capacity to function in the home environment
- Lack of probing around unrealistic patient and family optimism to manage at home
- Not recognizing a patient's worsening clinical status in the hospital;

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Typical Failures: (cont.)

- Lack of understanding of the patient's physical and cognitive functional health status resulting in a transfer to a care venue that does not meet the patient's needs
- Not addressing the whole patient (e.g., focusing on one condition, missing underlying depression, social needs, etc.);
- No advance directive

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Typical Failures (cont.)

- Not addressing palliative care or end of life issues including advance directives or planning beyond DNR status;
- Medication errors, poly-pharmacy and incomplete medication reconciliation
- Labeling the patient as noncompliant and not recognizing our responsibility to facilitate patient and family learning

Perform an Enhanced Admission Assessment for Post-Hospital Needs

Changes:

A. Involve family caregivers and community providers as full partners in completing a needs assessment of patients' home-going needs

B. Reconcile medications on admission

C. Create a customized discharge plan based on the assessment

Perform an Enhanced Admission Assessment for Post-Hospital Needs

A. Involve family caregivers and community providers
   - Contact community providers for information
   - Seek insight from family caregivers
   - Predict basic discharge needs on admission
   - Discover contributing causes for readmission from the patient and family perspective
   - Identify the key learners

Involve family caregivers and community providers

- What home-going needs or contributing causes for unplanned admissions or readmissions can we discover from:
  - Patient and family members?
  - Community providers who have seen the patient recently?
    - Physicians or office practice staff?
    - Home care nurses?
    - SNF or nursing home?
    - Rehab?
    - Dialysis center?

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B. Reconcile medications on admission

- Involve patient and family when taking medication history
- Check with patient's pharmacy and physicians if needed
- If home care has recently seen the patient, request their medication reconciliation list

Reconcile Medications on Admission

- Involve the patient and family caregivers, care providers, physicians, pharmacy
- Reconcile on admission (suitably trained professional)
- Include record of the reconciliation in the medical record
- Ensure drug changes during the admission are reconciled, updated, accurate and timely
- Consider using a personalized medication list or card for each patient to carry after discharge

Perform an Enhanced Admission Assessment for Post-Hospital Needs

C. Create a customized discharge plan based on the assessment.

- Use whiteboards to communicate plans and needs to the patient and family and care team
- Discuss discharge preparations daily
- Begin communicating with next care setting when home care or transitions coach referrals are planned

Heart Failure Work Group at St Luke's Hospital, Cedar Rapids, Iowa

Adding these views through the Cross Continuum team provided new context to our efforts.

- Home Care representative
- Family member of a patient with HF
- Long-Term Care representative
- Physician Clinic representative

Welcome To: Room Number: 408-B Phone #: 319-369-7561

Patient Name:

Please Call Me:

Today's Date:

Anticipated Discharge Date:

One Thing You Should Know About Me:

Plan and Goals For The Day:

The Most Important Thing To Me During My Hospital Stay:

Health Care Team:

Nurse:

Tech:

Doctors:

Therapists:

Test - Treatments - Procedures:

Diet:

Pain Management Goal:

Our Goal is to ALWAYS help control your pain!

0 1 2 3 4 5 6 7 8 9 10

My Pain Goal:

My Last Pain Medication:

Activity:

Safety Alerts/ Special Needs:

Family - Patient Comments:

Key Contact Person:

Quiet Time

12:30 pm to 1:30 pm / 2:00 am to 4:00 am:

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Interventions to Enhance Assessment for Post-Discharge Needs

- Take 5
- Daily discharge huddle at 10:00 AM
- Bedside reporting
- Both opportunities to review plan for day and anticipate discharge needs

St Luke's Hospital, Cedar Rapids, Iowa

Go Observe: “Be a patient”

- Identify a patient to observe on your 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 patient and family perspective
- What went well and what could improve?

Go Observe: “Be a patient”

What can you learn about the current state of these processes?

A. Involve family caregivers and community providers as full partners in completing a needs assessment of patients’ home-going needs.

B. Reconcile medications upon admission.

C. Create a customized discharge plan based on the assessment.

Process Measures

Enhanced Admission Assessment for Post-Hospital Needs:

- Percent of admissions where patients and family caregivers are included as full partners in assessing post discharge needs
- Percent of admissions where community providers (e.g., home care providers, primary care providers and nurses and staff in skilled nursing facilities) are included as full partners in assessing post discharge needs

What are we learning about enhanced assessments?

- Most teams think that they are already doing this; most have found that they gained new insights into what they are missing from doing the Diagnostic Reviews. Initial assessment should be completed upon admission, but ongoing assessment of home-going needs should occur throughout hospitalization.
- Teams should consider embedding questions from the Diagnostic Review into admission assessment for patients who have an unplanned admission to the hospital.
- Family caregivers are an important source of information about home-going needs of patients. There is often a discrepancy between the patient and the family caregiver's perception.
- 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.
- Completing a comprehensive admission assessment requires additional time; roles and responsibilities need to be designated and standard work processes need to be developed.