CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

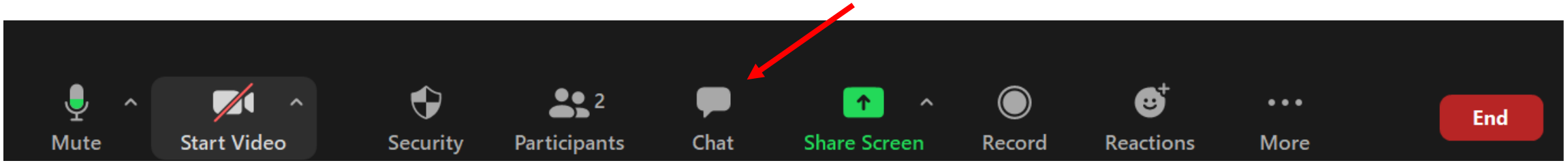
Pharmacy Quality Improvement Initiative Kick Off May 20, 2021

CARE TRANSFORMATION COLLABORATIVE OF R.I.

Zoom

Welcome! Please Chat in:

- Your Name and Organization



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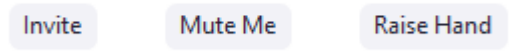
- ***Please use the 'Raise Hand' feature***



Agenda:

- Welcome & Introductions (Susanne Campbell)
- PQI Framework & Performance Reports (Steve Kogut)
- Practice Facilitation Background (Kelley Sanzen)
  - Mini Z Survey
- Review of Milestone Document (Susanne Campbell)
- Patient Voice & Needs (Maureen Maigret)

Special thanks to:

- *UnitedHealthcare*
- *Rhode Island Department of Health*
- *Rhode Island Asthma Control Program*

For providing funding for this initiative

Pharmacy QI Committee

- Susanne Campbell, *Care Transformation Collaborative of RI*
- Pano Yeracaris, *Care Transformation Collaborative of RI*
- Jazmine Mercado, *Care Transformation Collaborative of RI*
- Kelley Sanzen, *Care Transformation Collaborative of RI*
- Stephanie De Abreu, *Unitedhealthcare*
- Stephen Kogut, *University of Rhode Island*
- Deborah Newell, *Rhode Island Department of Health*
- Megan Fallon-Sheridan, *Rhode Island Department of Health*
- Maureen Maigret, *RI Long Term Care Coordinating Council*
- Neil Sarkar, *Rhode Island Quality Institute*

Introducing teams & brief description of project focus:

1. Anchor Medical Associates
- *Pharmacy Lead: Kenny Correia*

2. Coastal Medical- East Greenwich
- *Pharmacy Lead: Caitlin Kennedy*

3. Providence Community Health Center- Capitol
- *Pharmacy Lead: Lillian Nieves*

4. Rhode Island Primary Care Physicians
- *Pharmacy Lead: Diana Mercurio*

5. Women's Medicine Collaborative
- *Pharmacy lead: Safiya Naidjate*

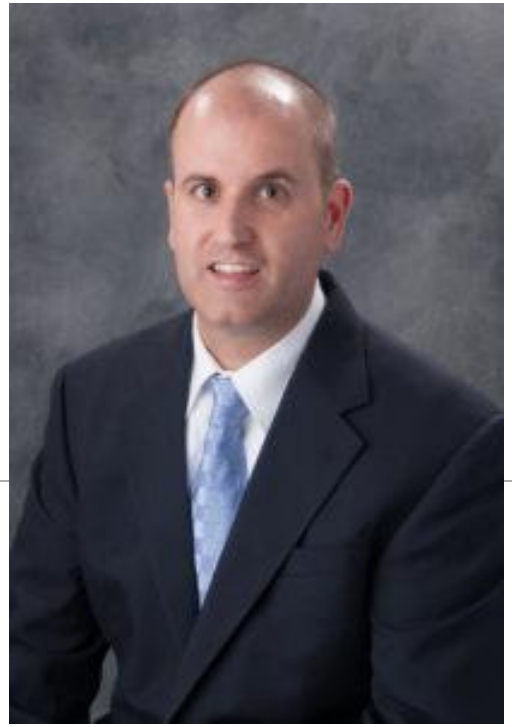
6. Thundermist Health Center
- *Pharmacy Lead: Jessica Ryan*

7. Medical Associates of RI
- *Pharmacy Lead: Alexander Pease*

PQI Framework & Performance Reports

STEPHEN KOGUT

PHD MBA RPH



Prevention Quality Indicators (PQI): Background

"The PQIs provide a good starting point for assessing the quality of preventive care in the community."

"…provide information on admissions for ambulatory care sensitive conditions that evidence suggests could have been avoided, at least in part, through better outpatient care."

Agency for Healthcare Research and Quality

AHRQ Quality Indicators—Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions. Rockville, MD: Agency for Healthcare Research and Quality, 2001. AHRQ Pub. No. 02-R0203. www.qualityindicators.ahrq.gov

US total stays, aggregate costs, and mean cost per stay for potentially preventable adult inpatient stays, 2017

Potentially preventable inpatient stays	Total stays, N	Aggregate costs, $ billions	Mean cost per stay, $
All conditions	3,530,900	33.685	9,500
Chronic conditions	2,720,800	27.261	10,000
Heart failure	1,112,600	11.240	10,100
Chronic obstructive pulmonary disease	825,800	7.273	8,800
Diabetes[a]	590,800	7.365	12,500
Diabetes long-term complications	281,200	4.304	15,300
Diabetes short-term complications	157,700	1.167	7,400
Uncontrolled diabetes	116,200	0.775	6,700
Lower-extremity amputation among patients with diabetes	78,200	2.110	27,000
Hypertension	160,600	1.194	7,400
Asthma in younger adults	31,300	0.195	6,200
Acute conditions	810,100	6.414	7,900
Community-acquired pneumonia	429,500	3.862	9,000
Urinary tract infection	380,600	2.550	6,700

McDermott KW (IBM Watson Health), Jiang HJ (AHRQ). Characteristics and Costs of Potentially Preventable Inpatient Stays, 2017. HCUP Statistical Brief #259. June 2020. Agency for Healthcare Research and Quality, Rockville, MD.

Adapting the PQI Measures for this QI Project

Include Emergency Department visits

Outcome: condition-specific denominators
- Numerator: Primary diagnosis

Data Source: HealthFacts RI 2019 (APCD)
- Includes most private insurance
- Medicaid
- Medicare Advantage

Measure composites

Exclusions

Measure Exclusions

Global
- In nursing home
- Under age 18

Heart Failure / HTN
- Cardiac procedures

Diabetes
- n/a

COPD / Asthma
- Cystic fibrosis
- Anomalies of the respiratory system

CAP
- Sickle cell anemia
- Immunocompromised

UTI
- Kidney/urinary tract disorder

Results: Overall v Systems of Care

Condition	RI APCD Cases	RI APCD ED	RI APCD Inpt	SoC Average ED	SoC Average Inpt
Heart Failure	14,555	15.4%	11.1%	17.5%	14.2%
Hypertension	158,835	1.7%	0.2%	1.7%	0.2%
DM: ST	65,858	2.7%	0.8%	3.4%	1.0%
DM:ST/LT	65,858	3.6%	1.4%	4.6%	2.0%
Asthma (Adult)	10,511	19.2%	2.6%	15.6%	3.2%
Asthma (Peds)	4,879	20.1%	3.1%	16.6%	3.1%
COPD	33,432	14.1%	3.8%	13.9%	4.9%
CAP	13,237	31.5%	5.2%	29.2%	6.2%
UTI	33,493	21.9%	1.4%	20.0%	1.9%

Green shade: > 1 point lower than RI APCD rate
Red shade: > 1 point higher than RI APCD rate

Definitions:
ED: Percent of cases with ≥ 1 ED visit
Inpt: Percent of cases with ≥ 1 inpatient stay

DM:ST is short term complications of diabetes
DM:ST/LT is short or long-term complications

SoC Average (in blue) is the mean rate across Anchor, Coastal, MARI, RIPCPC & Thundermist

Cells are empty where values could permit determining numerator < 11 cases

Results: Overall v Women & Higher Poverty Zip Code

Condition	RI APCD			SoC Average		APDC Women			Lower Poverty Zip			Higher Poverty Zip		
	Cases	ED	Inpt	ED	Inpt	Cases	ED	Inpt	Cases	ED	Inpt	Cases	ED	Inpt
Heart Failure	14,555	15.4%	11.1%	17.5%	14.2%	7,698	14.8%	10.5%	11,512	15.7%	11.4%	3,588	13.9%	9.8%
Hypertension	158,835	1.7%	0.2%	1.7%	0.2%	20,056	1.8%	0.2%	128,623	1.6%	0.1%	33,287	2.1%	0.2%
DM: ST	65,858	2.7%	0.8%	3.4%	1.0%	33,748	2.7%	0.7%	52,183	2.6%	0.7%	15,166	3.5%	1.0%
DM:ST/LT	65,858	3.6%	1.4%	4.6%	2.0%	33,748	3.3%	1.1%	52,183	3.4%	1.3%	15,166	4.5%	1.7%
Asthma (Adult)	10,511	19.2%	2.6%	15.6%	3.2%	7,444	18.8%	2.7%	8,275	18.2%	2.5%	2,574	23.7%	3.4%
Asthma (Peds)	4,879	20.1%	3.1%	16.6%	3.1%				3,797	19.6%	3.2%	1,226	22.7%	2.9%
COPD	33,432	14.1%	3.8%	13.9%	4.9%	20,056	14.8%	3.8%	25,952	13.6%	3.7%	8,563	16.1%	4.1%
CAP	13,237	31.5%	5.2%	29.2%	6.2%	7,504	30.7%	5.3%	11,000	30.9%	5.2%	2,682	34.3%	5.5%
UTI	33,493	21.9%	1.4%	20.0%	1.9%	27,521	22.6%	1.2%	27,309	21.0%	1.3%	7,268	26.3%	1.9%

Central Falls, Woonsocket, Providence, Pawtucket, Burrillville, more

Results by System of Care

Condition	RI APCD			Anchor			Coastal			MARI			RIPCPC			Thundermist			WMC		
	Cases	ED	Inpt	Cases	ED	Inpt	Cases	ED	Inpt	Cases	ED	Inpt	Cases	ED	Inpt	Cases	ED	Inpt	Cases	ED	Inpt
Heart Failure	14,555	15.4%	11.1%	437	13.5%	11.4%	1,896	17.9%	14.9%	425	15.5%	12.9%	518	20.5%	14.9%	367	20.2%	16.9%	>75	13.2%	13.2%
Hypertension	158,835	1.7%	0.2%		1.4%	0.1%	18,093	1.4%	0.1%		1.5%	0.2%		1.4%	0.2%	3,221	3.0%	0.4%	719	3.3%	< 11
DM: ST	65,858	2.7%	0.8%	1,859	2.5%	0.8%	6,499	2.8%	0.9%	1,471	2.2%	0.8%	1,730	3.5%	1.3%	1,730	6.0%	1.3%	>300	7.2%	3.0%
DM:ST/LT	65,858	3.6%	1.4%	1,859	3.3%	1.7%	6,499	3.9%	1.8%	1,471	3.5%	2.2%	1,730	4.9%	2.0%	1,602	7.5%	2.4%	>300	8.5%	4.3%
Asthma (Adult)	10,511	19.2%	2.6%		12.6%	2.0%	1,197	12.4%	3.8%	189	14.3%	<11	366	13.9%	4.1%	351	24.8%	4.6%	97	16.5%	<11
Asthma (Peds)	4,879	20.1%	3.1%		15.4%	3.3%		15.8%	2.1%				19	<11	<11		14.8%	3.7%			
COPD	33,432	14.1%	3.8%	843	11.4%	3.8%	3,941	12.5%	6.0%	669	10.8%	3.0%	1,125	14.8%	5.6%	1,188	20.0%	6.2%	207	18.8%	5.8%
CAP	13,237	31.5%	5.2%	329	28.6%	4.6%	1,566	27.2%	7.1%	350	30.9%	7.4%	455	26.4%	5.7%	376	33.0%	6.4%	>200	31.2%	6.5%
UTI	33,493	21.9%	1.4%	892	20.4%	1.7%	3,136	18.0%	2.1%	804	16.7%	2.1%	1,033	17.4%	1.8%	795	27.5%	1.9%	>200	21.8%	2.0%

Green shade: > 1 point lower than RI APCD rate
Red shade: > 1 point higher than RI APCD rate
WMC shadings reflect comparison with APCD Women (on previous slide)
Cells are empty where values could permit determining numerator < 11 cases

PCHC			
	Cases	ED	Inpt
Asthma (Peds)	>150	20.3%	3.4%
vs APCD:		+0.2	+0.3

Condition	RI APCD			SoC Average		Anchor			Coastal		
	Cases	ED	Inpt	ED	Inpt	Cases	ED	Inpt	Cases	ED	Inpt
Heart Failure	14,555	15.4%	11.1%	17.5%	14.2%	437	13.5%	11.4%	1,896	17.9%	14.9%
Hypertension	158,835	1.7%	0.2%	1.7%	0.2%		1.4%	0.1%	18,093	1.4%	0.1%
DM: ST	65,858	2.7%	0.8%	3.4%	1.0%	1,859	2.5%	0.8%	6,499	2.8%	0.9%
DM:ST/LT	65,858	3.6%	1.4%	4.6%	2.0%	1,859	3.3%	1.7%	6,499	3.9%	1.8%
Asthma (Adult)	10,511	19.2%	2.6%	15.6%	3.2%		12.6%	2.0%	1,197	12.4%	3.8%
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COPD	33,432	14.1%	3.8%	13.9%	4.9%	843	11.4%	3.8%	3,941	12.5%	6.0%
CAP	13,237	31.5%	5.2%	29.2%	6.2%	329	28.6%	4.6%	1,566	27.2%	7.1%
UTI	33,493	21.9%	1.4%	20.0%	1.9%	892	20.4%	1.7%	3,136	18.0%	2.1%

Condition	MARI			RIPCPC			Thundermist			WMC		
	Cases	ED	Inpt	Cases	ED	Inpt	Cases	ED	Inpt	Cases	ED	Inpt
Heart Failure	425	15.5%	12.9%	518	20.5%	14.9%	367	20.2%	16.9%	>75	13.2%	13.2%
Hypertension		1.5%	0.2%		1.4%	0.2%	3,221	3.0%	0.4%	719	3.3%	< 11
DM: ST	1,471	2.2%	0.8%	1,730	3.5%	1.3%	1,730	6.0%	1.3%	>300	7.2%	3.0%
DM:ST/LT	1,471	3.5%	2.2%	1,730	4.9%	2.0%	1,602	7.5%	2.4%	>300	8.5%	4.3%
Asthma (Adult)	189	14.3%	<11	366	13.9%	4.1%	351	24.8%	4.6%	97	16.5%	<11
Asthma (Peds)				19	<11	<11		14.8%	3.7%			
COPD	669	10.8%	3.0%	1,125	14.8%	5.6%	1,188	20.0%	6.2%	207	18.8%	5.8%
CAP	350	30.9%	7.4%	455	26.4%	5.7%	376	33.0%	6.4%	>200	31.2%	6.5%
UTI	804	16.7%	2.1%	1,033	17.4%	1.8%	795	27.5%	1.9%	>200	21.8%	2.0%

Practice Facilitation

KELLEY DOHERTY SANZEN

PHARM D, PAHM, CDOE

Practice Facilitator Role

- Monthly meetings to discuss project plan and program development strategy
- Facilitate care team well-being survey
- PDSA facilitation
  - Consult with practices to develop AIM statements and set SMART goals
  - Evaluate existing workflows and opportunities for improvement of team-based care
  - Select outcomes measures in conjunction with practices
  - Assist practice in developing patient engagement strategy
  - Identify at risk populations and implement risk stratification methods into workflows to optimize team-based care and provider well being
- Assist practices with action plan development and execution
- Report practice performance and goal attainment through monthly progress reports to CTC-RI

A focus on Team Based Care and Well-being

Mini Z survey 2.0 (for individual scoring)

Score

For questions 1-10, please indicate the best answer. (Numeric score indicated by number next to response.)

1. Overall, I am satisfied with my current job:

_____ 5=Agree strongly 4=Agree 3=Neither agree nor disagree 2=Disagree 1=Strongly disagree

2. Using your own definition of "burnout", please choose one of the numbers below:

_____ 5=I enjoy my work. I have no symptoms of burnout.
4= I am under stress, and don't always have as much energy as I did, but I don't feel burned out.
3=I am **beginning to burn out** and have one or more symptoms of burnout, e.g. emotional exhaustion.
2= The symptoms of burnout that I'm experiencing won't go away. I think about work frustrations a lot.*
1=I feel completely burned out. I am at the point where I may need to seek help. *
*If you select 1 or 2, please consider seeking assistance – call your insurance provider or employee assistance plan (EAP)

3. My professional values are well aligned with those of my clinical leaders:

_____ 5=Agree strongly 4=Agree 3=Neither agree nor disagree 2=Disagree 1=Strongly disagree

4. The degree to which my care team works efficiently together is:

_____ 1=Poor 2=Marginal 3=Satisfactory 4 =Good 5 =Optimal

5. My control over my workload is:

_____ 1 = Poor 2 = Marginal 3 = Satisfactory 4 = Good 5 = Optimal

_____

6. I feel a great deal of stress because of my job

_____ 1=Agree strongly 2=Agree 3=Neither agree nor disagree 4=Disagree 5=Strongly disagree

7. Sufficiency of time for documentation is:

_____ 1 = Poor 2 = Marginal 3 = Satisfactory 4 = Good 5 = Optimal

8. The amount of time I spend on the electronic medical record (EMR) at home is:

_____ 1=Excessive 2=Moderately high 3=Satisfactory 4=Modest 5=Minimal/none

9. The EMR adds to the frustration of my day:

_____ 1=Agree strongly 2=Agree 3=Neither agree nor disagree 4=Disagree 5=Strongly disagree

10. Which number best describes the atmosphere in your primary work area?

Calm Busy, but reasonable Hectic, chaotic
5 4 3 2 1

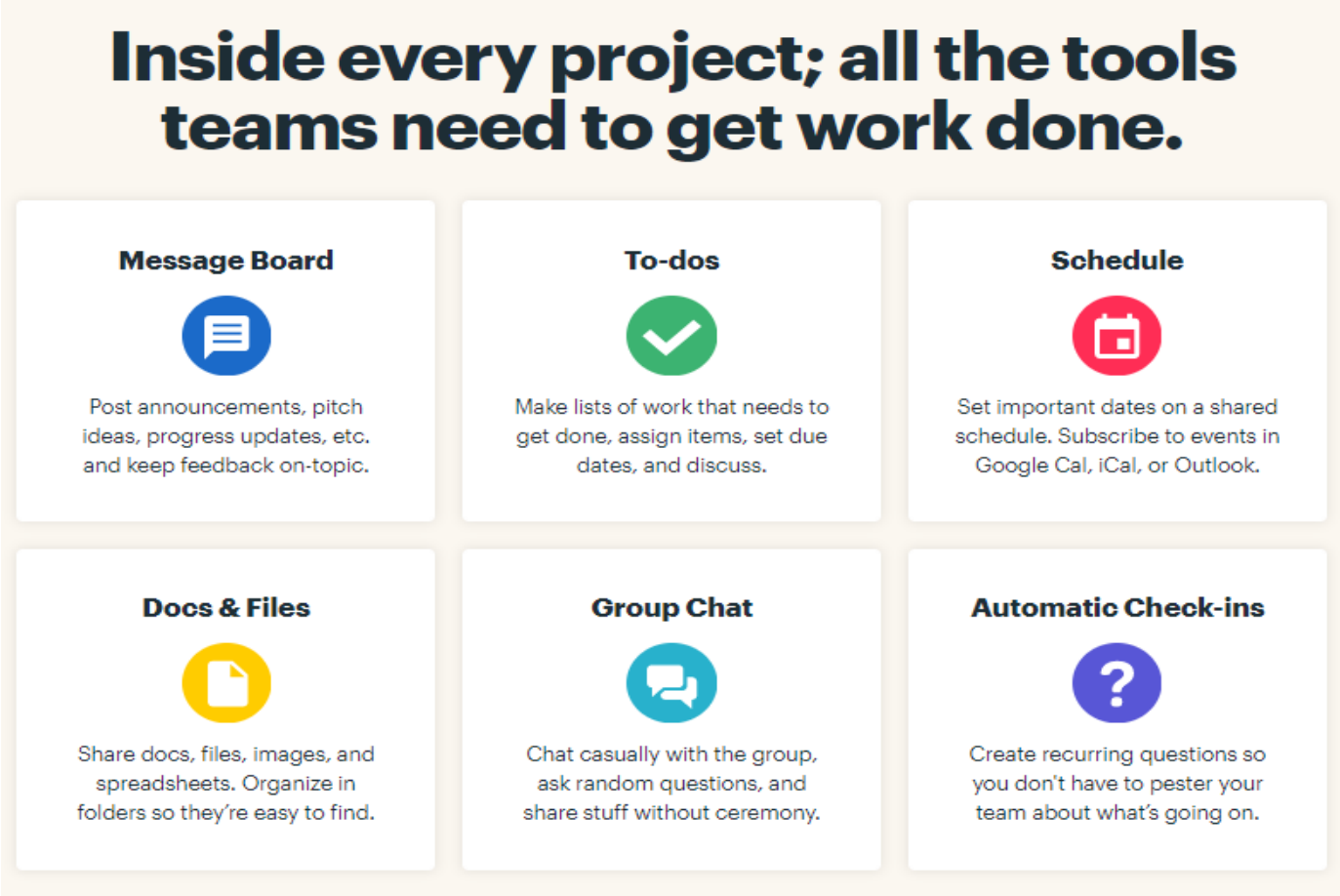
_____

Introduction to Basecamp

Basecamp is more than just a project management tool — it's a better way to work. Teams that switch to Basecamp are more productive and better organized.

Get organized and stay that way with Basecamp projects

- **A notification email will be sent to all team members today.**
- **Pharmacy QI Resources can be found on our basecamp project folder.**



Questions & Discussion

Patient Engagement

MAUREEN MAIGRET, RN, BS, MPA

Why Patient and Family Engagement

- **For Patients/Consumers**
  - Engagement ➡ Patient Activation
  - Improved Care Outcomes
  - Patient self-management of chronic diseases
  - Reduced Costs
  - Patient/Family Education Tools
    - Handouts
    - Teach Back
    - Mail: electronic and snail
    - Patient portals – Highly accepted
    - Webinars
  - Promotes Shared Decision Making
  - Identify **What Matters** to Patient
  - Understanding patient's cultural background and preferences is Important

- **For Family Caregivers/Advocates**
  - In RI, 136,000 unpaid family caregivers providing 100 Million hours care (AARP)
  - Supporting them is critical
  - Involving family members in decisions (with patient consent) and providing support and education ➡ drives positive experience
  - Several Laws require identifying family caregivers and assessing their needs
    - CARES **Caregiver Advise, Record, Enable)** Act – Hospitals must record if family caregiver is involved and need to be provided education on any nursing tasks they may be responsible for upon discharge home
    - For persons on Medicaid Home Care, if family helping with care, they must be assessed for needs and provided with resource information and education
    - Know what support programs available, esp. for carers of persons with Alzheimer's/other dementias. Alzheimer's virtual support groups; AARP programs **TCI** provides up to 4 weeks partial paid leave

"**The presence of a family member who will act as a fearless advocate is not just essential—it is a matter of survival.**"

from: ***"Passages in Caregiving: Turning Chaos Into Confidence,"*** by Gail Sheehy

Many Levels of Patient+Family Engagement

RI Examples of Organizational Design

- Provider Satisfaction Surveys
- Medicaid Consumer Advisory Committees; Medicaid Client Surveys
- AE Consumer Advisory Panels

Examples of Policy making

- Legislative Hearings
- Focus groups
  - No Wrong Door Alzheimer's State Plan

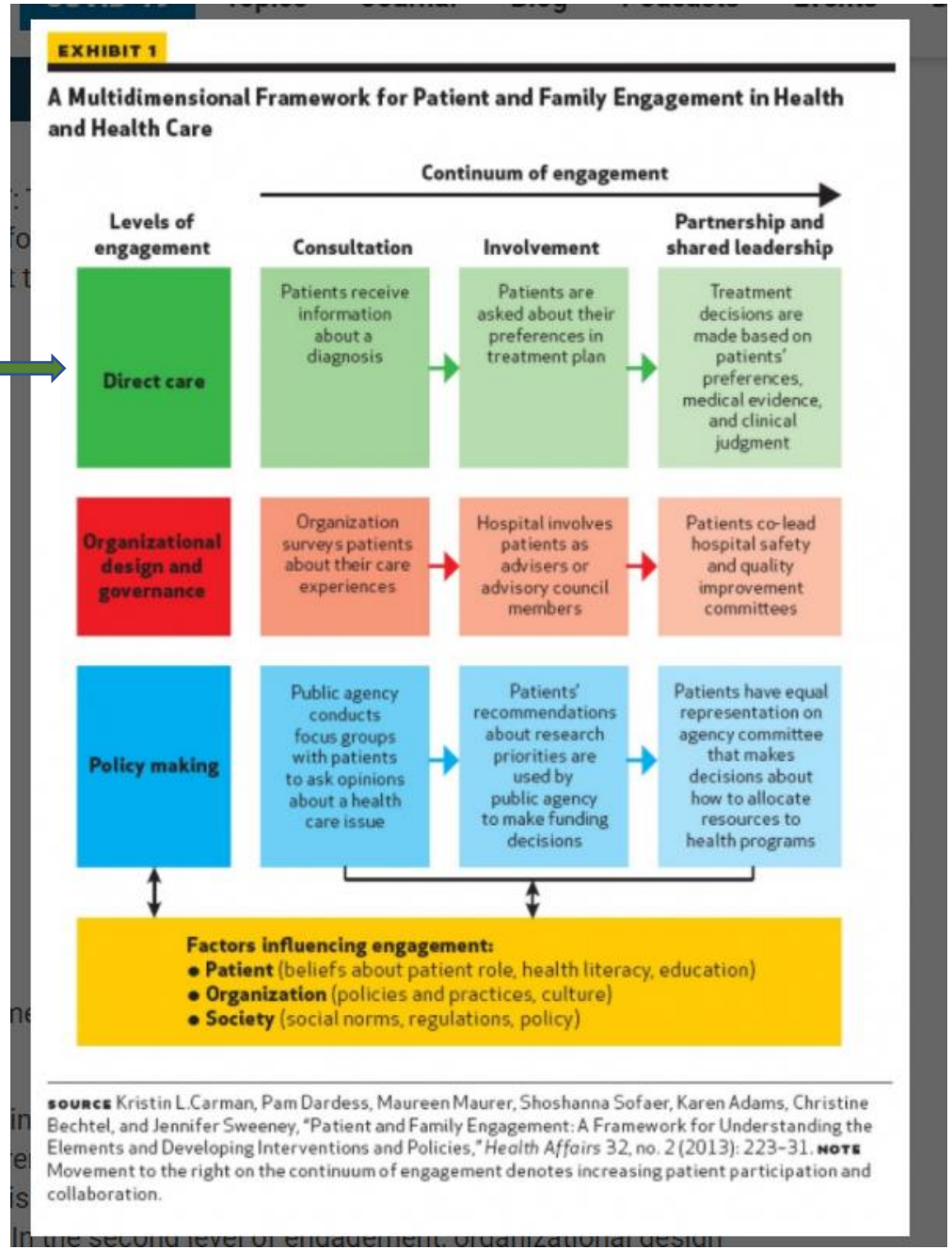


EXHIBIT 1

A Multidimensional Framework for Patient and Family Engagement in Health and Health Care

Levels of engagement	Continuum of engagement: Consultation	Involvement	Partnership and shared leadership
Direct care	Patients receive information about a diagnosis	Patients are asked about their preferences in treatment plan	Treatment decisions are made based on patients' preferences, medical evidence, and clinical judgment
Organizational design and governance	Organization surveys patients about their care experiences	Hospital involves patients as advisers or advisory council members	Patients co-lead hospital safety and quality improvement committees
Policy making	Public agency conducts focus groups with patients to ask opinions about a health care issue	Patients' recommendations about research priorities are used by public agency to make funding decisions	Patients have equal representation on agency committee that makes decisions about how to allocate resources to health programs

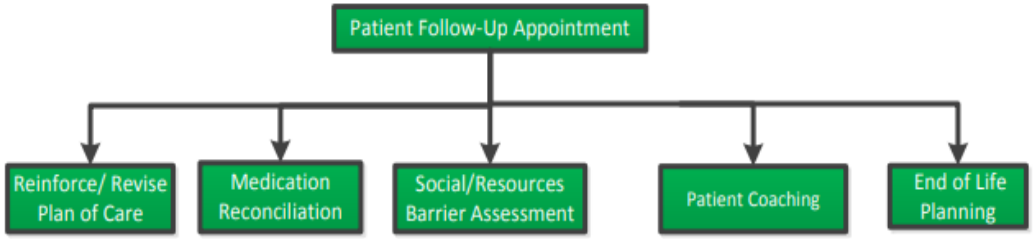
Factors influencing engagement:
- **Patient** (beliefs about patient role, health literacy, education)
- **Organization** (policies and practices, culture)
- **Society** (social norms, regulations, policy)

SOURCE Kristin L.Carman, Pam Dardess, Maureen Maurer, Shoshanna Sofaer, Karen Adams, Christine Bechtel, and Jennifer Sweeney, "Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies," *Health Affairs* 32, no. 2 (2013): 223–31. NOTE Movement to the right on the continuum of engagement denotes increasing patient participation and collaboration.

Pre-discharge Coordination

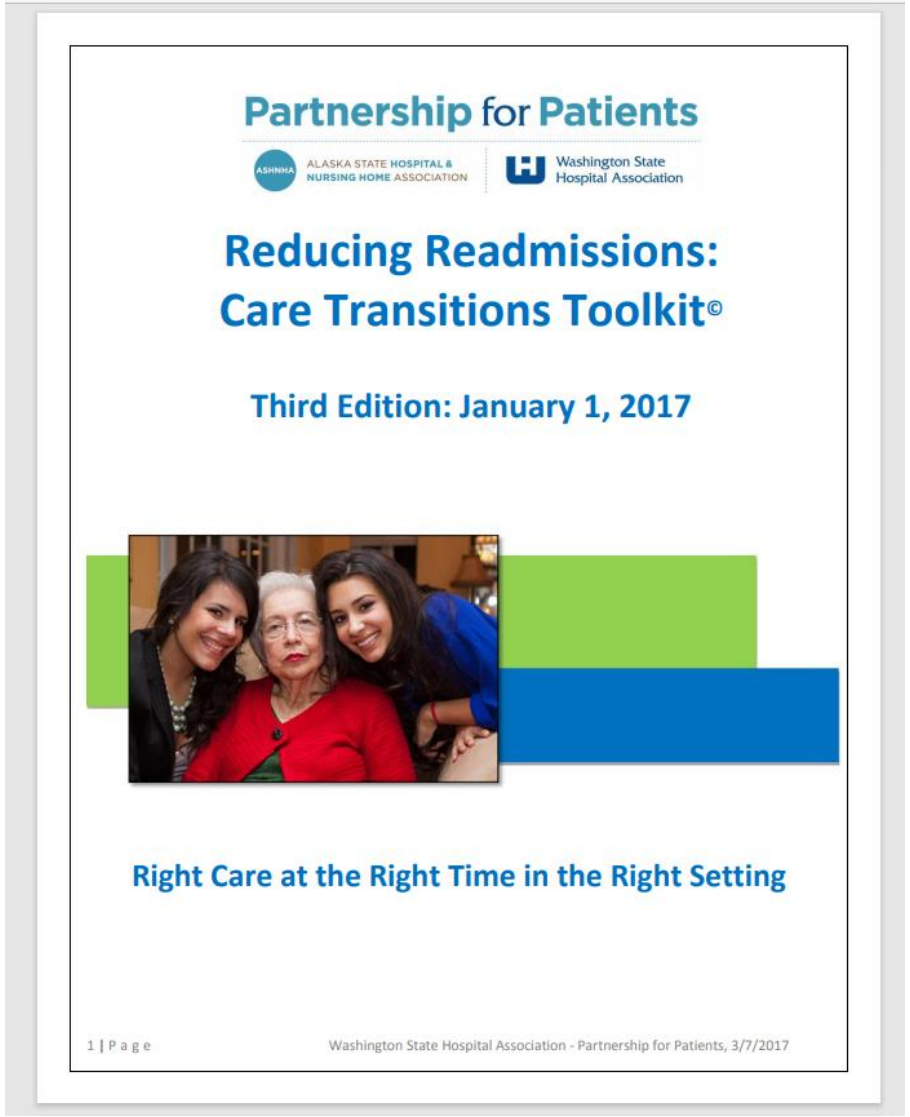
As part of discharge planning, find out what patient is going back to and their needs. Will they need Home Care follow-up? Do they live alone (as do 34% older RIers)? Do they understand what are warning signs? Do they have family/friends who can help in pinch? Do they have food in home or know how to get some? Know about the POINT (**462-4444)** for referral to community resources such as BE KIND RI for food delivery, PROJECT HELLO for friendly weekly call by vetted volunteer, digiAGE for digital education and technology needs and for accessing benefits for which they may be eligible.

11. Follow-up Appointment - Primary Care Visit



12. **Feedback to Hospital for Improvement**

Feedback to Hospital/ED for Quality Improvement



Partnership for Patients

ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION | Washington State Hospital Association

Reducing Readmissions: Care Transitions Toolkit©

Third Edition: January 1, 2017

Right Care at the Right Time in the Right Setting

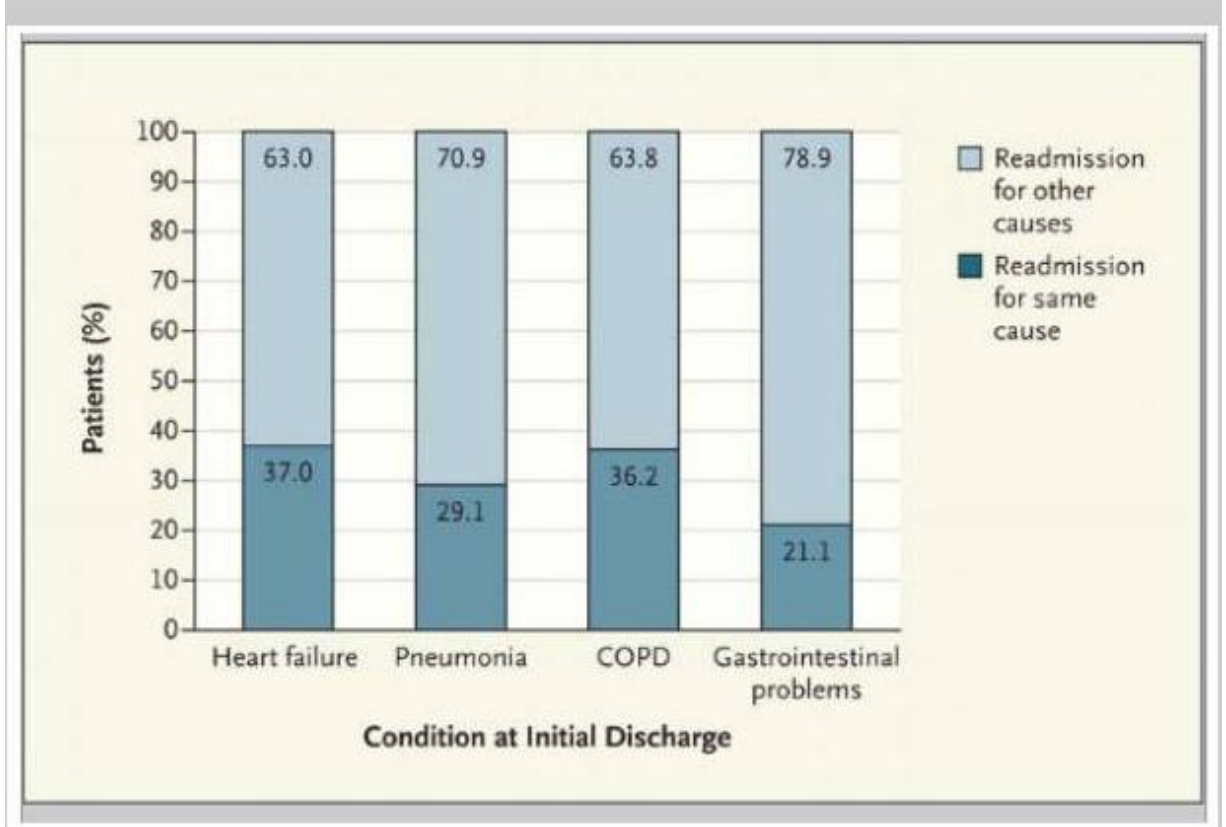
1 | Page

Washington State Hospital Association - Partnership for Patients, 3/7/2017

Post-Hospital Syndrome

- Nearly one-fifth Medicare patients discharged from a hospital develop an acute medical problem within 30 days and need readmission
- Many for reasons which have little in common with initial Dx.

Post-Hospital Syndrome-A Condition of Generalized Risk.
https://www.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&retmode=ref&cmd=prlinks&id=23301730



USEFUL RESOURCE: *ASSESSING THE 8P's*

Tool 1.2: The 8Ps: Assessing Your Patients Risk for Adverse Events after Discharge

project BOOST
Better Outcomes by Optimizing Safe Transitions

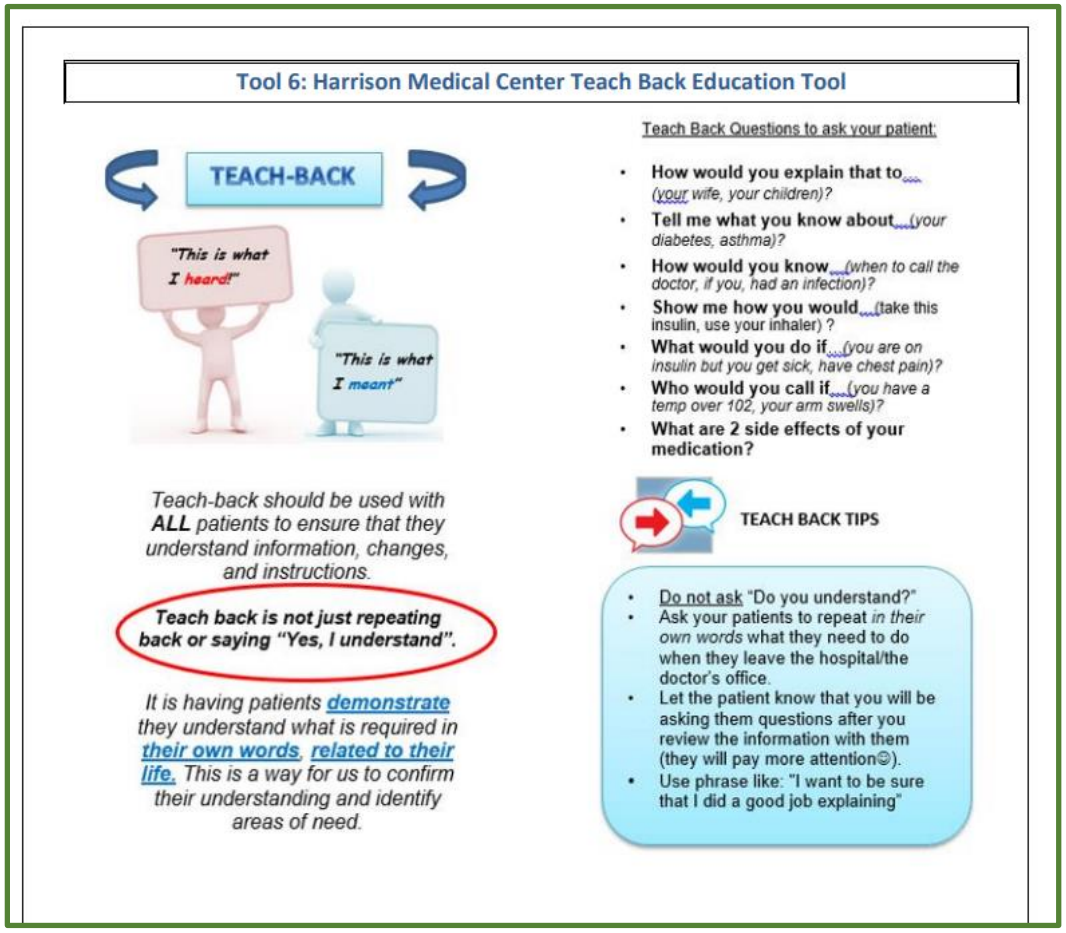
The 8Ps:
Assessing Your Patient's Risk For Adverse Events After Discharge

Risk Assessment: 8P Screening Tool (Check all that apply.)	**Risk Specific Intervention**	**Signature of individual responsible for insuring intervention administered**
Problem medications (anticoagulants, insulin, oral hypoglycemic agents, aspirin & clopidogrel dual therapy, digoxin, narcotics) ☐	☐ Medication specific education using Teach Back provided to patient and caregiver ☐ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin) ☐ Specific strategies for managing adverse drug events reviewed with patient/caregiver ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Psychological (depression screen positive or h/o depression diagnosis) ☐	☐ Assessment of need for psychiatric aftercare if not in place ☐ Communication with aftercare providers, highlighting this issue if new ☐ Involvement/awareness of support network insured	
Principal diagnosis (cancer, stroke, DM, COPD, heart failure) ☐	☐ Review of national discharge guidelines, where available ☐ Disease specific education using Teach Back with patient/caregiver ☐ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms ☐ Discuss goals of care and chronic illness model discussed with patient/caregiver	
Polypharmacy (≥5 more routine meds) ☐	☐ Elimination of unnecessary medications ☐ Simplification of medication scheduling to improve adherence ☐ Follow-up phone call at 72 hours to assess adherence and complications	

* P's Checklist Assessment Continued

☐	☐ Follow-up phone call at 72 hours to assess adherence and complications	
Poor health literacy (inability to do Teach Back) ☐	☐ Committed caregiver involved in planning/administration of all general and risk specific interventions ☐ Aftercare plan education using Teach Back provided to patient and caregiver ☐ Link to community resources for additional patient/caregiver support ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Patient support (absence of caregiver to assist with discharge and home care) ☐	☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with aftercare medical provider within 7 days ☐ Involvement of home care providers of services with clear communications of discharge plan to those providers	
Prior hospitalization (non-elective; in last 6 months) ☐	☐ Review reasons for re-hospitalization in context of prior hospitalization ☐ Follow-up phone call at 72 hours to assess condition, adherence and complications ☐ Follow-up appointment with aftercare medical provider within 7 days	
Palliative care (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness?) Yes to either: ☐	☐ Assess need for palliative care services ☐ Identify goals of care and therapeutic options ☐ Communicate prognosis with patient/family/caregiver ☐ Assess and address bothersome symptoms ☐ Identify services or benefits available to patients based on advanced disease status ☐ Discuss with patient/family/caregiver role of palliative care services and benefits and services available	

MORE USEFUL RESOURCES



Tool 6: Harrison Medical Center Teach Back Education Tool

TEACH-BACK

"This is what I heard!"

"This is what I meant"

*Teach-back should be used with **ALL** patients to ensure that they understand information, changes, and instructions.*

Teach back is not just repeating back or saying "Yes, I understand".

*It is having patients **demonstrate** they understand what is required in **their own words**, **related to their life.** This is a way for us to confirm their understanding and identify areas of need.*

Teach Back Questions to ask your patient:

- **How would you explain that to** *(your wife, your children)?*
- **Tell me what you know about** *(your diabetes, asthma)?*
- **How would you know** *(when to call the doctor, if you, had an infection)?*
- **Show me how you would** (take this insulin, use your inhaler) ?
- **What would you do if** *(you are on insulin but you get sick, have chest pain)?*
- **Who would you call if** *(you have a temp over 102, your arm swells)?*
- **What are 2 side effects of your medication?**

TEACH BACK TIPS

- Do not ask "Do you understand?"
- Ask your patients to repeat *in their own words* what they need to do when they leave the hospital/the doctor's office.
- Let the patient know that you will be asking them questions after you review the information with them (they will pay more attention☺).
- Use phrase like: "I want to be sure that I did a good job explaining"

The *IDEAL Discharge Planning* strategy highlights the key elements of engaging the patient and family in discharge planning:

- **Include** the patient and family as full partners in the discharge planning process
- **Discuss** with the patient and family five key areas to prevent problems at home:
  - 1. Describe what life at home will be like
  - 2. Review medications
  - 3. Highlight warning signs and problems
  - 4. Explain test results
  - 5. Make follow-up appointments
- **Educate** the patient and family in plain language about the patient's condition, the discharge process, and next steps **at every opportunity** throughout the hospital stay
- **Assess** how well doctors and nurses explain the diagnosis, condition, and next steps in the patient's care to the patient and family and use teach back.
- **Listen to** and honor the patient and family's goals, preferences, observations, and concerns.

* Source::Care Transitions from Hospital to Home: IDEAL Discharge Planning Implementation Handbook @ https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html

Importance of Patient Engagement
https://www.colleaga.org/article/importance-patient-engagement

Review of Milestone Document

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