



2011/2012 Picker Institute Always Events™ Challenge Grant Recipients



Organization/Institution: Quality Partners of Rhode Island

Principal Investigator(s): Stefan Gravenstein, MD, MPH

Project Title: Enhancing medication safety through PictureRx

Always Event(s): The family-patient team will always receive medication education using the teach-back method and then prior to discharge the patient will receive a visual medication schedule. (nursing home discharge communication)

Overview: Quality Partners will select up to five nursing homes currently participating in its Safe Care Transitions Project. The selected homes will have active involvement in the Safe Care Transitions Project and access to the appropriate technology. Quality Partners will partner with PictureRx, LLC for the use of the PictureRx software which results in a VMS. The VMS uses pictures to explain what medications the resident is taking, how to take it and why. In clinical trials patients felt the card helped them control their medications¹. The software will be installed in up to five participating nursing homes. Quality Partners associates will be trained with the nursing home staff on the use of the software. Additionally, Quality Partners staff will provided education on teach-back methodology that will be used to educate the patient and their family. Prior to discharge, the clinician at the participating facilities will complete the PictureRx VMS for the resident. They will then provide an education session for the patient-family team. Prior to leaving the facility the patient and family member will be given multiple copies of the VMS both for personal use and to share with the individuals' primary care physician at their follow up appointment



Organization/Institution: Massachusetts General Hospital
Principal Investigator(s): Richard H. L. Corder MHA, FACHE
Project Title: Always Know Your Caregiver/Always Responsive

Always Event(s): Ensure that our patients always know who is in charge of their care, and that providers are always responsive to the needs of our patients and their families and that our patients always get help when they need it.

Overview: The strategy that will be adopted will be a multi-factorial one, and will consist of a variety of approaches and tactics. These strategies will be piloted on a single, or a small number of homogeneous patient care unit(s) – using a similar unit(s) as a control. The specific strategies will be developed and deployed by staff, adjusted as they are deployed and then rolled out to the entire organization over the balance of the year remaining. It is expected that these strategies will be overseen and directed by the existing Communication and Responsiveness Council that reports to the Patient Care Services Committee – and will be influenced by the newly formed centralized Patient Family Advisory Council (PFAC). Strategies will include but will not be limited to: 1) A variety of rounding strategies to support and model the importance of timely responses to patients’ needs and their requests, 2) The production of a video that will welcome the patient and their family to the MGH, explain the environment, introduce the team that will be taking care of them and explain what they can expect in terms of our commitment to their care and well being, 3) The use of “face sheets” -- The sheet describes who is taking care of them, what their role is on the team and what they should expect from them. The face sheet contains actual photographs, names and pager numbers and descriptions of each team members roles and responsibilities, 4) White boards – in each patient room that detail who is taking care of the patient, their nurse, their doctor and other pertinent information that might help the patient better communicate with the right people, 5) Communication Boards – similar to the boards for patient rooms but designed for the nurse’s stations to communicate the monthly, quarterly and year to date patient satisfaction scores – especially “Staff Responsiveness.”



Organization/Institution: Planetree/Griffin Hospital
Principal Investigator(s): Michael Lepore, PhD
Project Title: Same Page Transitional Care: Creating a Template for Optimal Transitions

Always Event(s): Patients will always have the opportunity across healthcare settings to utilize a portable personal health record embedded with actionable patient-driven information, to ensure patients, their healthcare providers and their family members are on the same page with regard to the patient’s healthcare needs, priorities, and lifestyle.

Overview: To address transitional care challenges among older adults we propose *Same Page Transitional Care* as a Picker Always Event. The overarching goal of this low-cost initiative is to establish a template for the type of transitional care patients should always experience. Specific aims of this initiative include: (1) heightening patients' and informal caregivers' confidence in managing healthcare needs, (2) improving the quality of communication, coordination, and collaboration across care settings, and (3) reducing the frequency of unnecessary re-hospitalizations. To accomplish these aims we propose to launch a multidimensional initiative involving implementation of a validated web-based patient self-assessment tool (How's Your Health) that offers actionable information about what matters to patients, coordinated with a Care Partner program, wherein the patient and his/her informal (family/friend) caregivers are actively engaged in healthcare planning. We will introduce this *Same Page Transitional Care* initiative in the context of four hospital and nursing home dyads who have already implemented elements of effective transitional care. All dyads belong to Planetree's network of patient-centered healthcare organizations, and are therefore skilled and experienced in redesigning care processes with the patient at the center. Our focus on *Same Page Transitional Care* is intended to assure that patients, their informal caregivers, and healthcare providers across settings, particularly hospitals and nursing homes, are on the —same page|| with regard to patients' health and healthcare needs, and that this —page is grounded in patient-reported measures.



Organization/Institution: St. Jude Children's Research Hospital
Principal Investigator(s): Alicia Huettel; Patricia Aiken
Project Title: Parent Mentor Program

Always Event(s): The Always Event™ is proposed as having four goals: 1) to offer each newly diagnosed family at St. Jude a trained parent-mentor, offering support and encouragement throughout the trajectory of the child's treatment including the transition into survivorship or bereavement, 2) to provide the family the opportunity of acceptance, while facilitating coping mechanisms and hope, 3) empowering providers and the family as a partner and in their communication with St. Jude staff in their child's treatment, and 4) providing a resource of services offered by St. Jude and the community.

Overview: Our Always Event™ proposal is the development and implementation of a parent-mentoring program at St. Jude. During the first year we will: 1) outline the position description, recruit and train 3-10 parent mentors with an interdisciplinary team of chaplains, social workers, psychologists, physicians, nurses, and members of the FAC and Family Centered-Care Program, 2) formulate a program marketing plan to offer the Always Event™ to parents, 3) establish a communication process between mentors and parents, 4) create a formal documentation process, 5) establish the feedback process to interdisciplinary team including debriefing and support, 6) implement evaluation measurements, 7) assess the feasibility of program expansion within other clinics. A parent mentoring implementation team (PMIT) will be formed to assess the outlined steps and to offer feedback as the program is implemented. The PMIT will consist of members of the described interdisciplinary staff.



Best Outcome for Every Patient Every Time

Organization/Institution: Iowa Health System

Principal Investigator(s): Gail A. Nielsen

Project Title: Always Use Teach Back!

Always Event(s): The Always Event is to always listen to the patient during hand-offs by encouraging teach-back opportunities—during hospitalization and upon arrival in the next care setting. Always use the Teach-back method.

Overview: IHS will develop and implement a “Always Use Teach-back!” toolkit for the three care settings encountered by patients being discharged from the hospital: hospital discharge, primary care follow-up, and home health support. The toolkit will include training modules with videos demonstrating effective use of teach-back. IHS will train and coach physicians and nurses on the “Always Use Teach-back!” approach.

The Always Events encompass Teach-Back (T-B) opportunities – during a patient’s hospitalization and upon arrival in the next care setting. Physicians and nurses will educate and discover (in a non-shaming way) what the patient or family caregiver understood using T-B. The aim is to have patients/family caregivers able to teach back in their own words:

- danger signs and symptoms to watch for after discharge from hospital
- action steps if signs or symptoms occur
- key medications related to principal diagnosis
- critical self-care activities
- follow-up appointments

IHS has the ongoing benefit of patient and family advisors in developing appropriate T-B interventions through their HLC, partnership with the New Readers of Iowa7, and Reducing Readmissions Collaborative. IHS patient and family caregivers will be partners in developing and testing the most effective T-B learning system.



Organization/Institution: PFCC Innovation Center at University of Pittsburgh Medical Center

Principal Investigator(s): Anthony M. DiGioia, III, M.D.

Project Title: Care Team Twittering and Guardian Angels

Always Event(s):

- Always let the patient be the center of the care team... Care Team Twittering
- Always keep patients and family members informed... “Guardian Angels”
- Always know the discharge plan and beyond... Transitions in Care Experiences

Overview: Trauma Services and the Transplant Programs at UPMC have incorporated the PFCC Methodology and Practice (PFCC M/P) in their care delivery approach. The PFCC M/P approach enables Care Givers to deliver truly exceptional care experiences by refocusing existing resources through a six step process that brings patients and families directly into co-designing care delivery improvement. PFCC M/P will serve as the means by which the 2 always events will be incorporated, monitored, evaluated, disseminated, and accelerated locally and nationally so that accurate communication takes place in real time and transitions in care are seamless.



A teaching hospital of Tufts University School of Medicine

Organization/Institution: Lahey Clinic
Principal Investigator(s): Elizabeth Collins, M.D.
Project Title: Transitions of Care Partnership Project

Always Event(s): Always listen to and involve the patient in their care transitions. This community partnership project ensures that patient-provider communication occurs and will improve the delivery of patient-centered care at each step in the discharge or transfer process from one setting to another.

Overview: Shaped by the premise that better health care requires better information exchange at all stages of the health care process,² the Transitions of Care Partnership project has emerged as a multi-project, multi-disciplinary effort. Through a network of dedicated transition liaisons, aided by personalized patient education tools and materials, the project strengthens communication between patients, physicians and healthcare institutions by directly involving patients and caregivers in planning at and between each level of care. By directly engaging patients in their care planning, we seek to reduce rates of avoidable re-hospitalizations and medical/medication error, and improve patient and caregiver well-being along the continuum of care. Incorporating the Picker Institute's guiding themes of communication, with an emphasis on care transitions, Transitions of Care improves institutional processes, and emphasizes effective and efficient communication through activities centered on the patient's individual needs and concerns.



Organization/Institution: Anne Arundel Health System
Principal Investigator(s): Sherry B. Perkins, PhD, RN and Mitchell Schwartz, MD
Project Title: The SMART Discharge Protocol

Always Event(s): Always provide the patient with a SMART discharge process. With the involvement of patients and families providers will develop a simple, universal, 5 item checklist as a SMART Discharge ProtocolSM. (SMART is an acronym for: Signs, Medications, Appointments, Results, and Talk with me.) Providers will build on current evidence; create urgency and expectation for use with patients, families, and caregivers; disseminate findings, and promote as a national standard.

Overview: Develop with patients and families a universal SDP as a discharge Always Event. The SDP includes: 1) The SDP process that results in a written plan—SMARTtool, 2) Curriculum for patients, families, staff: Process for using SMARTtool throughout stay as Worksheet and at discharge as a Checklist, 3) Patient access to inpatient/ambulatory records. This initiative will be implemented on three units (surgery, medicine, obstetrics) to demonstrate universality.



Organization/Institution: Saint Joseph Hospital Foundation
Principal Investigator(s): Wendy Rockey
Project Title: Comfort & Pain Relief Menu

Always Event(s): Patients will ALWAYS be offered every option and/or combination of options for pain control and comfort. Nurses will ALWAYS have a more comprehensive conversation about pain & comfort with every patient.

Overview: This proposal is to create and implement, as an Always Event, a “Comfort & Pain Relief Menu” to be offered with every pain/comfort assessment. This will include a broad list of pain relief and comfort measures for caregiver and patient to discuss together so they can create a comprehensive pain & comfort plan. The hope with this grant is to create a color, picture-aided, patient-friendly tool (resembling a restaurant menu), which will offer a widely comprehensive list of options on the menu, including: pharmacologic options, medication-combination options and/or a visit from the pain nurse, heat/cool therapies, positioning and movement, distraction, music and/or massage. In addition, comfort items like sleeping eye masks, neck pillows, warm blankets, aromatherapy, or ear plugs would be offered.



Organization/Institution: INOVA Health Systems

Principal Investigator(s): Mary Ann Friesen, PhD, RN, CPHQ

Project Title: Developing a Patient-Centered Approach to Handoffs

Always Event(s): Patients will always be included in the ISHAPED handoff shift-to-shift hand-off process at the bedside as this will add an additional layer of safety by allowing the patient to communicate potential safety concerns.

Overview: This project will build on previous research by the Inova Health System (IHS) to improve the quality and safety of patient care by enhancing communication and encouraging patient participation. Recent reviews of patient safety and satisfaction at Inova identified the shift-to-shift handoff as a process in need of improvement. Inova responded by convening a quality-improvement team to develop a new strategy for conducting the shift-to-shift handoff, one that standardizes procedures and incorporates a bedside component. Entitled "ISHAPED" (I=Introduce, S=Story, H=History, A=Assessment, P=Plan, E=Error Prevention, and D=Dialogue), this strategy also provides patients and their families the opportunity to participate in the handoff process. The proposed project aims to 1) measure patient satisfaction and perceptions regarding the ISHAPED bedside handoff process, 2) use the patient feedback to optimize and standardize the bedside handoff process, and 3) develop a training video and companion toolkit to educate nurses on how to conduct a safe, effective and patient-centered bedside hand-off across multiple settings.



Organization/Institution: University of California San Francisco

Principal Investigator(s): Carla Graf, RN, MS, PhD(c)

Project Title: Improving Patient and Family Centered Care for Hospitalized Persons with Dementia

Always Event(s): The *Always Event* will be that patients with dementia and their families receive care that is targeted to the patient's type and stage of dementia.

Overview: This initiative is designed to improve the care of hospitalized patients who have dementia. Our overall goals are to enhance patient and family-centered care by partnering with families to guide patient care, improving family knowledge and readiness regarding the hospital experience, and fostering continuity across the different sites of care. The *Always Event* will be that patients with dementia and their families receive care that is targeted to the patient's type and stage of dementia and to their specific care needs. Implementation of a "Dementia Bundle" that facilitates continuity of care and safety for the hospitalized patient with dementia. Components of the Dementia Bundle include a targeted assessment upon admission with the patient's family regarding personal care routines of the patient (communication, hygiene, nutrition, and day/night activities) that will be used to guide hospital care. Families will be provided an educational video that details aspects of the hospital experience and strategies for prevention of negative sequela. Families will also be provided an educational packet focused on hospital and post-hospital concerns.



Organization/Institution: Northeast Valley Health Corporation

Principal Investigator(s): Ursula Baffigo, MD

Project Title: Team Up for Health

Always Event(s): Always help prepare our patients for their office visits through the *Making the Most of Your Visit* form. Spread utilization of the MMV tool from the pilot site to all 7 of their primary health clinics. Patients complete the form while in the waiting room prior to each visit. The 2 questions are: 1) How am I managing my health; 2) What do I want to ask my doctor today.

Overview: The MMV tool is designed to be completed by patients in the waiting room prior to each visit, asking, 1) "how am I managing my health?" and 2) "What do I want to ask my doctor today?" The tool is then brought into the exam room with the patient and discussed with the provider. 3 NEVHC staff members are certified to facilitate 4 hour workshops that will teach providers and support staff communication skills and techniques that have been proven to increase positive patient behavior change. Combined with the utilization of the MMV tool, these skills and techniques have demonstrated to greatly assist providers in initiating a conversation with patients regarding their health, thus helping lay the foundation for a true patient-provider partnership. In order to ensure the Always Event is properly executed, this initiative will implement 8 four-hour Choice and Change workshops. These workshops will give providers and staff the skills necessary to effectively listen and communicate with their patients, as well as how to fully utilize the MMV tool. Patient surveys will be distributed to 70 randomly selected adult patients, 18+ years of age, per quarter across our six targeted sites. Surveys will assess effectiveness of the intervention program, including the effectiveness of the MMV tool.



Organization/Institution: Yale-New Haven Children's Hospital
Principal Investigator(s): Janet Parkosewich, DNSc, RN, CCRN, FAHA

Project Title: Premature Life Transitions: A Patient- and Family-Centered End of Life Care Program for Neonates

Always Event(s): Our proposal for the Always Event™ Grant is aimed at the consistent use of an innovative, systematically applied end-of-life program by all members of our neonatal interdisciplinary team to support patients and families during the transition from curative to palliative care, infant demise, and bereavement.

Overview: A major tenet of *Transitions* is to improve compassionate, family-centered communication among interdisciplinary team members and between this team and grieving parents who are facing the death of their newborn. Our intention is to advance the role of parents from visitors to partners and decision-makers who are actively involved in caring for their critically ill infant. There are several modes of communication between healthcare providers and families underlying *Transitions*. Our multidimensional approach will include enhancements in verbal, non-verbal, written, electronic, and symbolic modes of providing compassionate effective communication to families. Six Sigma methods will provide the structure for assessing team members' performance related to *Transitions* processes of care. Incremental improvements over time are anticipated through the use of Six Sigma DMAIC (define, measure, analyze, improve, control) cycles.



UNIVERSITY OF MINNESOTA
Amplatz Children's Hospital

Organization/Institution: University of Minnesota Amplatz Children's

Principal Investigator(s): Cheristi Cognetta-Rieke, RN

Project Title: My Story

Always Event(s): Upon every admission and transition in care a questionnaire-based interview will occur between the intake nurse, the patient and the patient's family or friends. The interview will specifically focus on the personality and interests of the patient, such as hobbies, nicknames, pets, and special interests. The "story" of each individual patient will be used as a consistent approach to involving the child in the delivery of patient care.

Overview: Development and implementation of a multifaceted intervention, MyStory, to have all care interactions with children begin with a meaningful conversation between care providers, patients, and families. MyStory will capture the patients' values, preferences, and expressed needs, and document it where it can be viewed and used by all care team members. Implementing MyStory as an *Always Event* as children are admitted to the hospital will ensure we capture the "story" of each child and use the information to involve children in care decisions and care planning. The MyStory application will be built into the electronic medical record that is used throughout our system of hospitals and clinics. It will be designed by a project team that includes nurse managers, a bedside nurse, the organizational development manager, child family life staff, a member of the Patient and Family Centered Care Task Force, a child from the Kids Council, and parents from the Parent Advisory Board. Adaptation will be lead by MyStory Champions, chosen from each of the inpatient departments. A MyStory kick-off event will be held to gain buy-in and excitement. Education will be developed and delivered to more than 500 direct care interprofessional staff.



Organization/Institution: Dartmouth-Hitchcock Medical Center

Principal Investigator(s): Jonathan T. Huntington, MD, PhD & Sandra G. Dickau, RN, MS

Project Title: Implementation of a set of Always Events that will increase communication

Always Event(s): Always communicate with, inform and respect the patient through the following behaviors in every patient/family encounter:

- Introducing yourself and describing the reason you are there at each encounter
- Addressing and referring to patients by the name that they choose; not by their disease
- Displaying your name badge at all times
- Treating those whom you serve with the same respect you would wish them to show you
- Encouraging patients and families involvement in decision making
- Welcoming and being respectful to those defined by the patient as "family"

Overview: Develop and implement a educational practice intervention and improvement program to promote and evaluate the competency of frontline clinical nurses with a set of observable and behavioral Always Events. Intervention is based on experiential learning provided with simulation and fully integrating Patient Family Advisors who will serve as Standardized Patients in a clinical scenario. The efforts will build from a foundation of pre-existing resources and educational infrastructure. Specific Aims include: To operationally define measurable behaviors that demonstrate competence in specific PFCC Always Events involving communication. To Enhance a nationally recognized experiential education program targeting recently hired nurses to create immersive learning experiences utilizing SPs that will serve as a pilot for the evaluation and practice of these Always Events. To provide education to SPs regarding the importance of these behaviors and how to provide targeted feedback to learners. To Develop a novel evaluation method to measure the effects of this intervention on the clinical practice of recently hired nurses.



Organization/Institution: Vanderbilt University Medical Center

Principal Investigator(s): Terrell Smith

Project Title: Effective Communication and Collaboration with Patients and Families for Falls Prevention

Always Event(s): Patients and families will always receive information and education to facilitate autonomy, self-care and health promotion. This communication strategy educates patients as to how they can partner with the health care team to prevent a fall during their stay.

Overview: This study will evaluate the effectiveness of adding patient and family engagement strategies across a multi-linguistic, automated delivery platform to reduce falls in hospitalized patients. A generic falls video will be produced that is appropriate to be shown in hospitals across the country. This video will be translated into Spanish, Arabic, Kurdish and Somali. Two pilot units will be selected for this additional falls prevention information. The other adult units will serve as control units giving out the falls prevention information currently in use. The nurses on the pilot units will be given information and coaching on the TV system pilot and ask to encourage their patients to watch the video. A message will be pushed out asking the patient/family to watch the video. The interactive TV system will track number of times the video is watched on each unit/month. The number of falls will be tracked per unit by the SciHealth system.



Organization/Institution: Cleveland Clinic

Principal Investigator(s): Jennifer Ramsey, MD

Project Title: Unmet expectations regarding ICU patient outcomes: Identification and management of at risk families

Always Event(s): Always assure that MICU patients and families understand and participate in their care through:

- Timely, ongoing, clear, consistent and compassionate communication
- Medical decision-making aligned with patient values, care goals, and treatment preferences
- Family care that includes liberal visiting and practical, emotional, spiritual and bereavement support

Written materials to improve understanding of critical illnesses and the rights and responsibilities of critically ill patients and their families.

Overview: The program will use multiple strategies for implementation, primarily by leveraging existing resources within our healthcare system. In addition to our critical care providers, we will use palliative care, spiritual care and family liaison personnel, coupled with feedback from bioethicists, and current/past MICU patients/families to develop processes and tools for improving communication and continuity of care. Our multi-disciplinary team will develop a predictability tool to identify at-risk patients and communication strategies for patients/families for all caregivers.

- Multidisciplinary work group will develop clinician communication skills training program, including conducting family conference in MICU.
- Providers will solicit focus group input from current and former patients/families concentrating on positive and negative MICU experiences and their suggestions for improvement.
- Providers will also seek patient and family input for the development of written resources for families.



Organization/Institution: March of Dimes

Principal Investigator(s): Liza Cooper, LMSW

Project Title: Close to Me

Always Event(s): March of Dimes considers kangaroo care, or skin-to-skin holding of the premature infant by the parent as an Always Event(s)[™] that is discrete, affordable and measurable. It has numerous proven health benefits for mother and baby and is indicated as one of the most comforting activities by NICU families. *Close To Me* is the intervention program being implemented to increase the early onset and frequency of kangaroo care in NICUs.

Overview: *Close To Me* is a comprehensive set of awareness and educational activities, tools and products designed to increase the early onset and frequency of kangaroo care and other positive holding experiences in a NICU. Under the Picker Grant, *Close To Me* will be implemented in 12 NICU Family Support sites, four that are currently conducting evaluation of the program and eight new sites. A *Close To Me* parent education hour will be offered monthly in each of the 12 sites in English and Spanish to give parents and caregivers an opportunity to learn about the benefits of kangaroo care. It will be conducted by the March of Dimes NICU Family Support Specialist in collaboration with the NICU nurse educator or lactation consultant, in a location easily accessible by NICU families. *Close To Me* brochures will be distributed to all NICU families in each of the 12 sites. Educational activities and materials are intended to contribute to parental confidence in asking for, initiating and conducting kangaroo care. Each NICU family in the 12 *Close To Me* implementation sites will be offered items that will encourage kangaroo care and contribute to making it a positive experience. Items may include: hand mirrors to view their infant during kangaroo care, standing mirrors, privacy screens and comfortable chairs. This is intended to make the kangaroo care experience positive, private, intimate and comfortable. NICU Staff will receive *Close To Me* presentation/training conducted by the March of Dimes NICU Family Support Specialist and other members of the health care team. Additional educational information and motivators will be provided to staff to reinforce their promotion of kangaroo care.

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Organization/Institution: American Academy of Pediatrics

Principal Investigator(s): Aditee Narayan, MD, MPH, FAAP; Marcia Jackson, PhD

Project Title: Family Feedback—*Always!* (FFA)

Always Event(s): To develop and assess a pilot program designed to facilitate communication strategies used by pediatric residents for eliciting feedback from the families they serve in continuity clinics—“Family Feedback—ALWAYS! [FFA]”.

Overview: The materials developed under the auspices of this grant will be incorporated within a “Feedback from Families” instructional module and will be pilot tested with PGY3 residents in nine training programs: (1) three programs will serve as a control group, whose residents will not receive the module materials; (2) three programs will receive the instructional materials that conclude with the residents developing a plan to acquire feedback from families (experimental group 1); and (3) three programs will receive the instructional materials that conclude with the residents implementing a plan to acquire feedback from families (experimental group 2). The training programs will be selected from among those that apply and are accepted to be part of the pilot program; every effort will be made to match the control and experimental groups with respect to program size and geographic locale. The pilot program will take place over a 12 month period and will be administered as one activity within the continuity clinic required of all residents in the pilot program sites. The “Feedback from Families” module will be delivered through the National Center’s web site in an area specifically designated for this purpose and available only to the pilot sites. The FFA project team (see below) will also provide technical assistance and host quarterly conference calls for each individual cohort (ie, control and experimental groups 1 & 2).

Health Care For All

Organization/Institution: Health Care For All
Principal Investigator(s): Deborah Wachenheim
Project Title: Patients and Families Improving Hospital Discharge

Always Event(s): This initiative will create, in partnership with the PFACs and STAAR teams at Massachusetts hospitals, a discharge process that consistently and meaningfully engages patients (and their caregivers) in identifying the patient's needs at home. It is consistent with the criteria for selection of an Always Event and is closely aligned with the principles of the Picker Institute.

Overview: Health Care for All (HCFA) has joined together with the Massachusetts Coalition for the Prevention of Medical Errors (MA Coalition) to bring the patient and family voice into improving the hospital discharge process in order to decrease preventable readmissions and improve health and quality of life post-discharge. The project will result in a process where those being discharged (and their caregivers) and those managing the discharge have a full and shared understanding of the patients' needs, abilities and access to assistance post-discharge. As a result, the capacity of Massachusetts' hospitals to listen to consumers will increase, as will the level of consumer engagement with hospitals as they work together to design a consumer-centered discharge process.



Organization: Henry Ford Health System
Principal Investigator(s): Dr. Rhonna Shatz, D.O.
Project Title: Dementia Screening for Senior Patients

Always Event: HFHS will develop a new "Always Event" that will screen patients 70 years and older for dementia as part of their annual primary care health exams.

Overview: This initiative will use a new Web-based cognitive assessment tool developed by the National Institutes of Health and modified for use at HFHS. Physicians will also utilize an NIH developed web-based smart survey tool to assess mood, behavior, daily living activities and review caregiver distress. Should the patient exhibit any signs of a neurological impairment following the cognitive screen, the doctor would initiate a full dementia assessment guided by EMR templates that can be downloaded or utilized and saved on-line as an office note. Our program will involve training and preparing Primary Care Physicians (PCPs) within the hospital to observe senior adult patients during regular office visits to determine whether an undiagnosed neurological condition, especially Alzheimer's disease, is present. While general practice physicians do regularly see a high proportion of senior adults, most do not typically have current expertise or knowledge in neurological medicine as it applies to age-related

conditions. HFHS will conduct training to provide as many physicians as possible with techniques to quickly assess their senior patients. On-going training would then be held for newly hired doctors or as a refresher course for others. Should the patient exhibit any signs of a neurological impairment following the cognitive screen, the doctor would initiate a full dementia assessment guided by EMR templates which can be downloaded or utilized and saved on-line as an office note.