Care Transitions Done Right

10

Transition of Care

HCAHPS Breakthrough Series

Thank You **Partners**

Center for Rural Health
University of North Dakota
School of Medicine & Health Sciences

MN Rural Health Access & Choice Cooperative

North Carolina Association For Healthcare Quality

Wyoming ORH
Your Partner in Rural Health

Hawaii State Department of Health

Colorado Rural Health Center
The State Office of Rural Health

Nevada Rural Hospital Partners

ICAHN
Illinois Critical Access Hospital Network

afmc

New England Rural Health Association

NMDOH
New Mexico Department of Health

Nebraska
Dept. of Health and Human Services

Indiana Rural Health Association

Hawai'i State Rural Health Association

Oregon Office of Rural Health

Medi-Sota
Serving Rural Healthcare

OHA
Oklahoma Hospital Association

Louisiana Hospital Association

Missouri DHSS
Department of Health and Senior Services

Custom Learning Systems
1.800.667.7325 www.customlearning.com

Transition of Care

Care Transitions Done Right™

To engage staff and patients in creating a seamless care transition experience.

Question: Are you playing a form of 'telephone' with care transitions at your facility?

Healthcare isn't a game….
The poor communication of meaningful information is inefficient, expensive – and potentially life-threatening for patients and families

> *""Many patients are discharged without understanding their illnesses or treatment plans, or inadvertently discontinue important medicines needed to stay well."*
> -The Dartmouth Institute for Health Policy

Care Transition Questions and Why They Matter

Care Transitions Defined:

- Within a facility, where care is transferred from one setting to another
- From hospital to home, where care is transferred to the patient, family, or other home caregivers
- From one healthcare facility to another, where care responsibilities are transferred from providers at one facility to another. These include Assisted Living, Skilled Nursing, or Long-Term Care residences

HCAHPS Domain – Transition of Care
Survey Question #1: (Patient Preferences)
The hospital staff took my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I left the hospital.

Survey Question #2: (Patient Responsibility)
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

Survey Question #3: (Patient Medication Education)
When I left the hospital, I clearly understood the purpose of taking each of my medications

Domain Staff Owners:
Case Managers, Nurses, Transitional Care Manager, Social Worker, Transition Coach, Staff Members

Domain Leadership Owners:
CEO, CMO, Chief of Staff, Physicians, Nurse Practitioners, Physician Assistants

Current National Threshold is;
(Rated a 4 – "Always"/50th Percentile)

51%

What's Yours? _____%

HCAHPS Facts Worth Noting:

- "Handoffs and Transitions" was consistently the second-lowest-scoring area in a survey of over 1000 hospitals nationwide. - AHRQ Pt. Safety, 2011
- In this same survey, caregivers said:
  - "Things 'fall between the cracks' when transferring patients between units…"
  - "Important patient care information is often lost during shift changes…"

Got Ineffective Care Transitions? Here's What You're Looking at:

1. **Adverse Events.** About 1 in 5 patients suffer an adverse event during the care transition period. Medication-related events are the most common.
2. **Unnecessary Readmissions.** About 1 in 5 patients are re-hospitalized within 30 days of discharge. Of these readmissions, 75% are potentially avoidable.
3. **Unnecessary Pain and Suffering** often occurs when patients are **not properly educated** about how to successfully manage pain at home
4. **Poor HCAHPS Scores and Financial Penalties**. Patients who suffer from poorly-managed discharges and care transitions **reflect their dissatisfaction on their HCAHPS** survey. Poor scores lead to unnecessary financial penalties for the hospital.
5. **Transitions of Care Ratings are Public Sample.** Patients who reported that they "Always" understood the purpose of taking each of their medications.
6. **Ineffective Care Transitions Are Costly. "**In the second year of the HRRP, beginning October 1, 2013, CMS estimates 2,225 hospitals will be penalized a total of $227 million because of excess readmissions."- *Source: Health Affairs Journal, November 12, 2013*

Mastering Transition Moments of Truth

The Million Dollar Transition Question:
How to seamlessly handoff the patient between:

- Different departments
- Different shifts
- Different healthcare institutions
- Different home settings

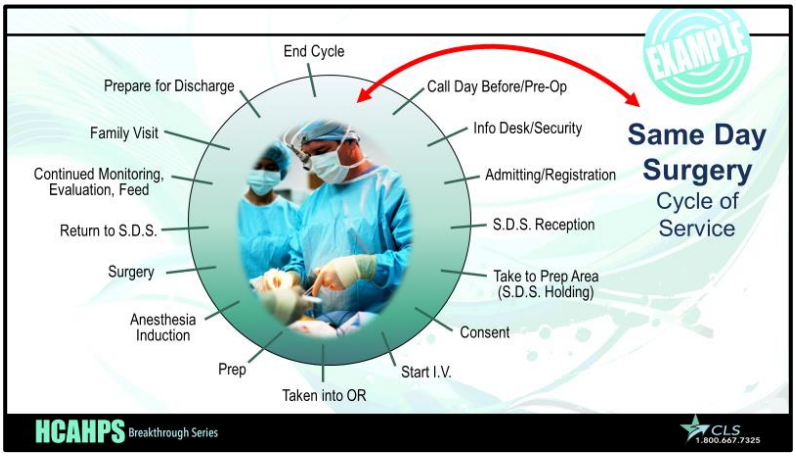
…without dropping the ball because of poor communication, weak collaboration, and listless coordination of care?

Answer: *Empower **everyone** to manage your patients' **Moments of Truth**.*

Moment of Truth
Any interaction in which a patient comes in contact with the care transition process.

A Reward Strategy
Pays off each Moment of Truth, allows patient to have the very best experience at each point of contact.

Cycle of Service
Any combination of Moments of Truth.

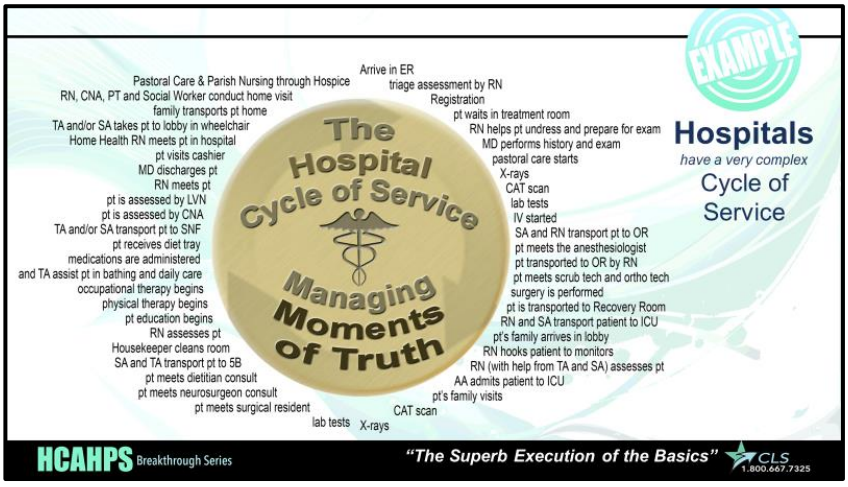


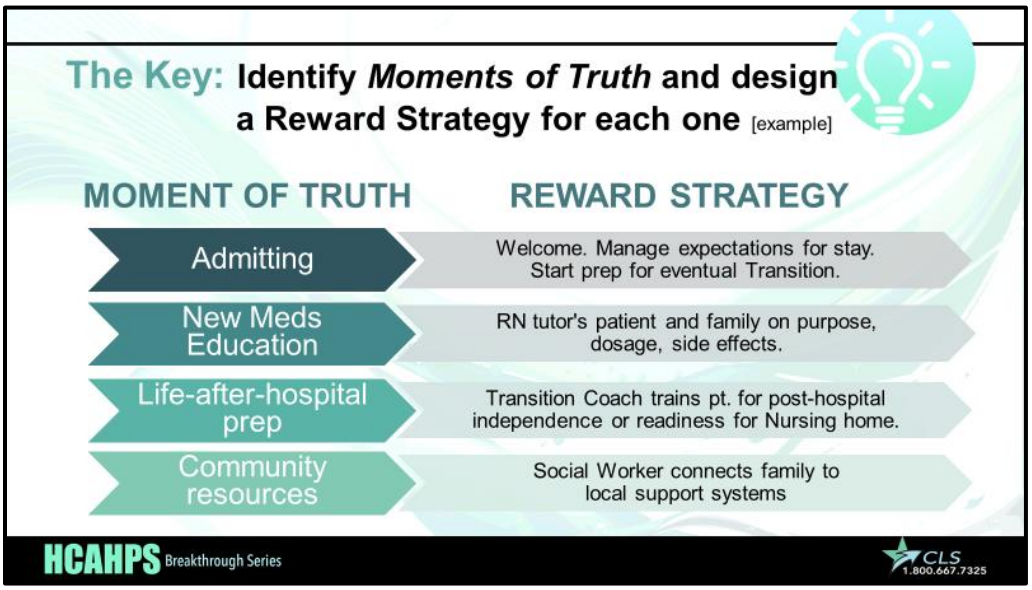
Every "Moment of Truth" Involves a Hand-Off

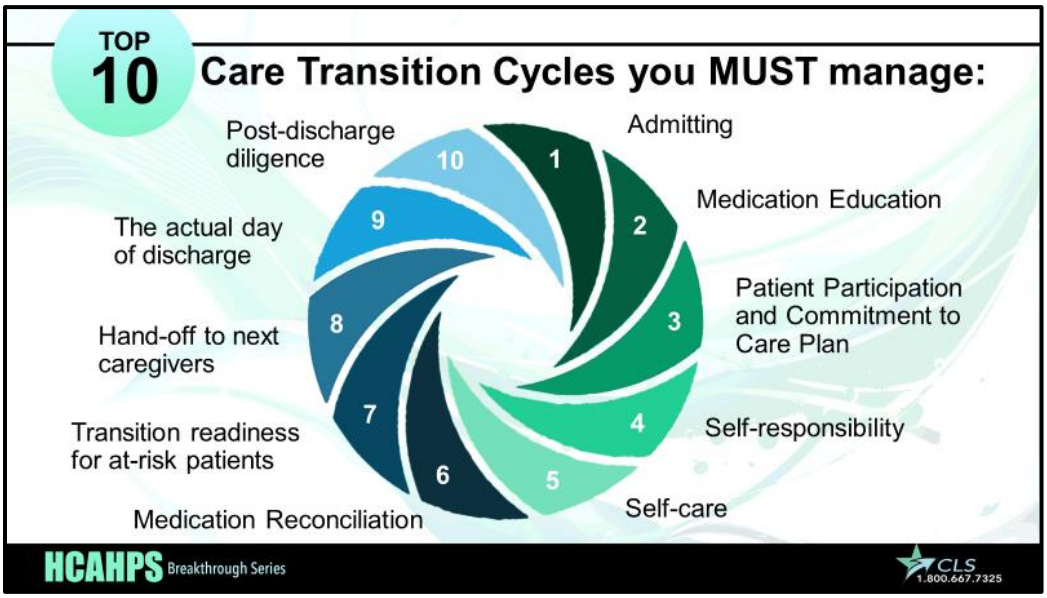
*"**Hand-offs occur** any time there is a transfer of responsibility for a patient from one caregiver to another..."*

*"**The goal of the handoff** is to provide timely, accurate information about the patient's care plan, treatment, current condition, and any recent or anticipated changes."*

-Lee Ann Runy, *Hospitals & Health Networks*, 2008







What would be the value of…
Conducting this "Cycle of Service" for each "dissatisfier" in your care transition process?

Benefits

- Involves all staff (everybody contributes!)
- Creates ownership (if they create it – they'll own it!)
- Sets norms for staff behavior (no fear of missteps)
- Empowers all staff as educators
- Gives patients reliable road maps to recovery
- Prepares family as confident support team
- Assures timely healing at home or care facility
- Reduces unnecessary readmissions
- Creates satisfied patients. Fewer CMS penalties

Personalized Care Plan

How good are you and your fellow team members at creating effective Personal Care Plans?

> **To retrieve the feature tool **Personalized Care Plan:***
> *Please fill out the evaluation at the end of the lesson for access to this tool. **

Take the conversational initiative to learn patients' preferences!
On admission to the hospital:

- Patients want and expect their values and priorities to be discussed with their MD's and Nurses, but they rarely initiate these conversations
- Patients expect to discuss their preferences with their caregivers but expect the physician or nurse to take the initiative in these conversations

Questions:

- How skilled/prepared are you in starting values/priorities conversations?
- Can you say something like this?
  - "*Now that I've taken your medical history, would you like to spend some time to talk about things that are on your mind? For example, what's your biggest concern about this hospital stay? What would you like to know from me, Mr. Smith?"*

How to gather personal information

- In some cases (religion, ethnicity) you can work the question into a conversation
- In others (medical literacy, decision-making, influence of social norms) your interpersonal conversation will provide clues giving you insight into their abilities and family dynamics

Patient Accountability for Self-Management

Question:
When and how will you be confident your patient is ready for a safe transition to their next level of care?

Accountability for Self-Management
Teach patient and family to be *active, responsible participants* in the self-management of the healing process

Teach what's Needed for a Safe Transition:

- Education for life after a hospital stay should not begin two hours before discharge.
- Let patients/family know that when they leave the hospital they become, by default, their own Care Coordinator.
- Encourage patients to assert that role, and tell health professionals what they need.
- Teaching about diet, exercise, following med. regimens, etc. should be ongoing, daily.

You'll know patients are self-reliant and ready for discharge when they:

- Participate actively in their care plan
- Know their diagnosis and prognosis
- Speak confidently about meds – aware of side effects
- Working with determination at PT, other therapies
- Have already set goals for rehab, recovery
- Are supported by knowledgeable family caregivers

Have you reason to believe patient will need extra care post-discharge?
Your responsibility is to alert:

- Attending physician
- Case Manager
- Social Worker
- Next care facility (if transitioning to SNF, etc.)
- Patient's family
- Or other home caregivers
  … to the fact this patient is potentially "at risk" and will need supervision

Tools, Equipment and Resources

Question:
Are you effectively using all the discharge/transition tools available?

The Journey Home White Board:
In-room white boards are re-titled ***"The Journey Home"***

- They contain all pertinent care transition data

A take-home Discharge Packet

- Carries all relevant written information (including follow-up appointments, medication reminders, emergency numbers, etc.)
- Is reviewed by clinician, with patient and home caregivers
- Is a fool-proof way to assure that patients know they've been given "written instructions" at discharge

Smart Phone Apps/Internet

- There are 1,000s of helpful smart phone apps
- Check with your pharmacist, physicians and managers to confirm approved apps you can recommend

Discharge Checklist

Discharge Preparation Checklist

Before I leave the care facility, the following tasks should be completed:

- ❑ I have been involved in decisions about what will take place after I leave the facility.
- ❑ I understand where I am going after I leave this facility and what will happen to me once I arrive.
- ❑ I have the name and phone number of a person I should contact if a problem arise during my transfer.
- ❑ I understand what my medications are, how to obtain them and how to take them.
- ❑ I understand the potential side effects of my medications and whom I should call if I experience them.
- ❑ I understand what symptoms I need to watch out for and whom to call should I notice them.
- ❑ I understand how to keep my health problems from becoming worse.
- ❑ My doctor or nurse has answered my most important questions prior to leaving the facility.
- ❑ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- ❑ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

Review "Discharge Satisfaction Guaranteed" Webinar, for common issues and best practices

Care Transition Sentence Starters

Question
Would you agree that it's crucial we get it right when communicating with patients about their transition to home or next level of care?

A Working Model for Teach Back
"Please do me a favor and explain, in your own words, what I said… I want to make sure you have a good understanding of the signs and symptoms to watch for at home, since you'll be responsible for monitoring them."

Words to Ensure Understanding of Meds & Self-Care at Home
Use "teach-back" and "show-back"
"So that I'm sure you know how to change your dressing… will you please show me how you'd remove and replace it?"
"Your new prescriptions are important. Can you tell me what the two medications are for, when you'll take them, and what to do if you miss a dose?"
"Here's a quick quiz: How will you apply your blood pressure cuff?"

Words to encourage use of Care Transition Packet at Home
"We've put a good deal of thought into this packet. It contains your medication information, upcoming appointments, emergency names and numbers of everyone you'll need to contact if you have questions or need help. It's divided into five sections. Let me show you how they're arranged and what's in them."

Words to help Set Goals for Recovery at Home:
"What else do you need in order to feel safe during your recovery at home?"
"What's the most important thing I can do for you as you prepare to go home?"
"What's something you really want to accomplish in your first week at home, and how can I help you reach that goal?"

Sentence Starters to support a Patient's Positive Outlook
"It won't be long before you'll…"
"I like the way you listen to your body and what it needs..."
"People like you don't usually take any longer than they need… (in order…) to…"
"Slow but sure is often best… as you continue to recover."
"Your wound is healing. The tissue is a pink and clean."

Care Transition Team

Question:
What would be the value and impact of establishing your own Care Transition Team?

> **To retrieve the feature tool **Care Transition Team Charter:***
> *Please fill out the evaluation at the end of the lesson for access to this tool. **

Care Transition Vital Questions

An Observation
"Poor Care Transitions: when getting there is not half the fun"

Three Thoughtful Questions that ensure Improved HCAHPS Scores
The Key to Earning an "Always"

The hospital staff **took my preferences and those of my family or caregiver into account** in deciding what my healthcare needs would be when I left the hospital.

- *"Did we take all of your personal preferences into account in designing your plan of care for when you go home?"*
- *"What did we miss that we should include?"*

When I left the hospital, I had a **good understanding of the things I was responsible** for in managing my health.

- *"What do you see as any potential barriers to your ability to be responsible for managing your health at home?"*
- *"What's a question about home care you never got to ask us?"*

When I left the hospital, I clearly **understood the purpose of taking each of my medications**.

- *"Just for my benefit, can you tell me about the meds you're taking?"*
- *"Can you tell me what the possible side effects are for the two medications you're going home with?"*
- *"And what do you do if you experience those side effects?"*
- *"What meds already at home are you to stop taking and throw away?"*

The Accountability First Step:

Who **W**ill do **W**hat by **W**hen & **H**ow?

What's the BEST idea you've heard on this webinar?

- _____
- _____
- _____

How **soon** will you put it/them to use?

_____

_____

Tools & Resources

Tools

To support your team to achieve its HCAHPS performance improvement goals, we are pleased to offer these value added Educational Resources and Implementation Tools. For more information give us a call at 800-667-7325 x2202, or email webinars@customlearning.com.

☐ **Thirty Minute Coaching Call** *(Complimentary)*
Problem solve & overcome barriers with this powerful value added Webinar Series benefit.

☐ **Brian Lee**, CSP, HoF, **Live Stream Keynote Presentation**

- Magic of Engagement™ (90 minutes)
- How to Win Back Every Single Patient™ (60 minutes)
- How to Inspire Caregiver Heroes Everyday™ (60 minutes)
- Reignite Your Community Reputation™ (60 minutes)

☐ **Ignite the Patient Experience™** (Administrative fees only)
A comprehensive 2 day Service Engagement and dynamic 4 hour HCAHPS Leadership Seminar

☐ **The Everyone's a Caregiver® App**
A time-sensitive web-based learning tool to educate and empower everyone in your hospital, and improve patient satisfaction scores.

- HCAHPS based Patient Experience Skills for Everyone™
- Relationship based HCAHPS Skills for Nurses™
- The Patient Centered Clinic™
- Transform the Resident Experience™

☐ **HealthCare Service Excellence Conference** - HealthCareServiceExcellenceConference.com

- HealthCare Service Excellence Live Stream Summit
- HealthCare Service Excellence Full 3 day Destination Conference
  - Includes the Annual CAHPS Symposium

Participant Satisfaction Report **PLEASE PRINT**

HCAHPS Breakthrough Leadership Series

This Evaluation Page can be accessed online: Click Here to complete online.
Or, Email/Fax this form: webinars@customlearning.com / 403-228-6776

You've just heard from me, now I'd like to hear from you. Evaluation is the "genius" of growth and we sincerely value your contribution to this learning experience. Thank you.

We **totally employ** about #_____ full and part time staff, at _____ facilities.

1. **For me, the most valuable idea I learned and intend to use is**:_____

   _____

   _____

2. **What I would tell others about the quality of the speakers and value of the content**: _____

   _____

   _____ O.K. to quote me: YES NO

3. **Presentation improvements I would suggest**:_____

   _____

   _____

4. **On a scale of 1 - 5, this presentation:** (Met My Expectations) 5 4 3 2 1 (Did Not)

5. ***Featured Implementation Tool:***

   Yes A. Skilled Nursing Organization Tool
   Yes B. **Personal Care Plan** Checklist
   Yes C. **Care Transition** Team Charter
   Yes D. Interested in Scheduling Our **Team Coaching Call**

6. **P.S. – My Best Tip**: _____

   _____

   _____ ❑ More on Reverse

PLEASE PRINT

First/Last Name:_____
Organization: _____ Position:_____
Address:_____ Zip: _____
Bus. Phone:(____) _____ Extension:_____ Cell: (____)_____
*Email:_____