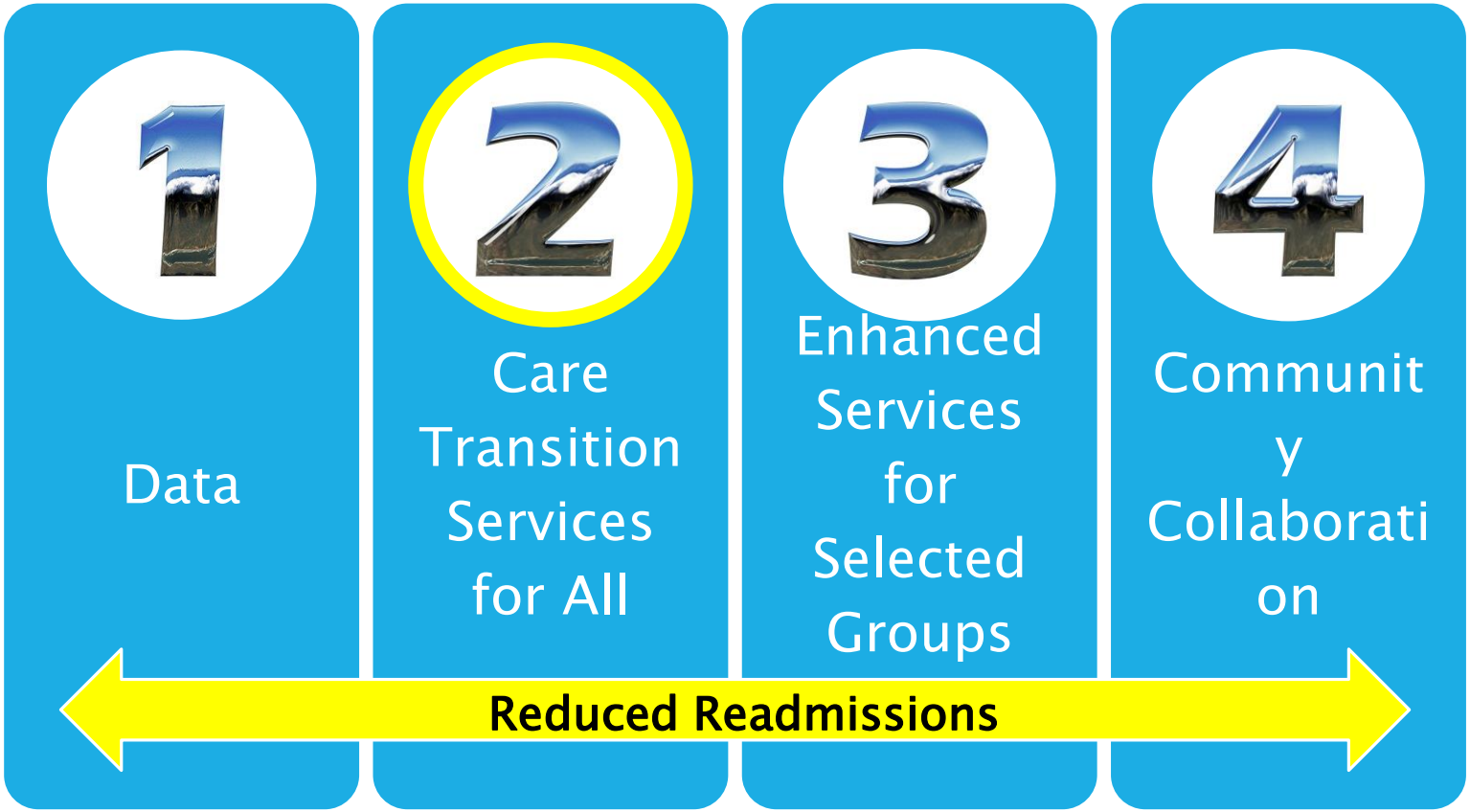
THE KEY DRIVERS: | Transitional Care for All

READMISSION DRIVERS



TRANSITIONAL CARE FOR ALL

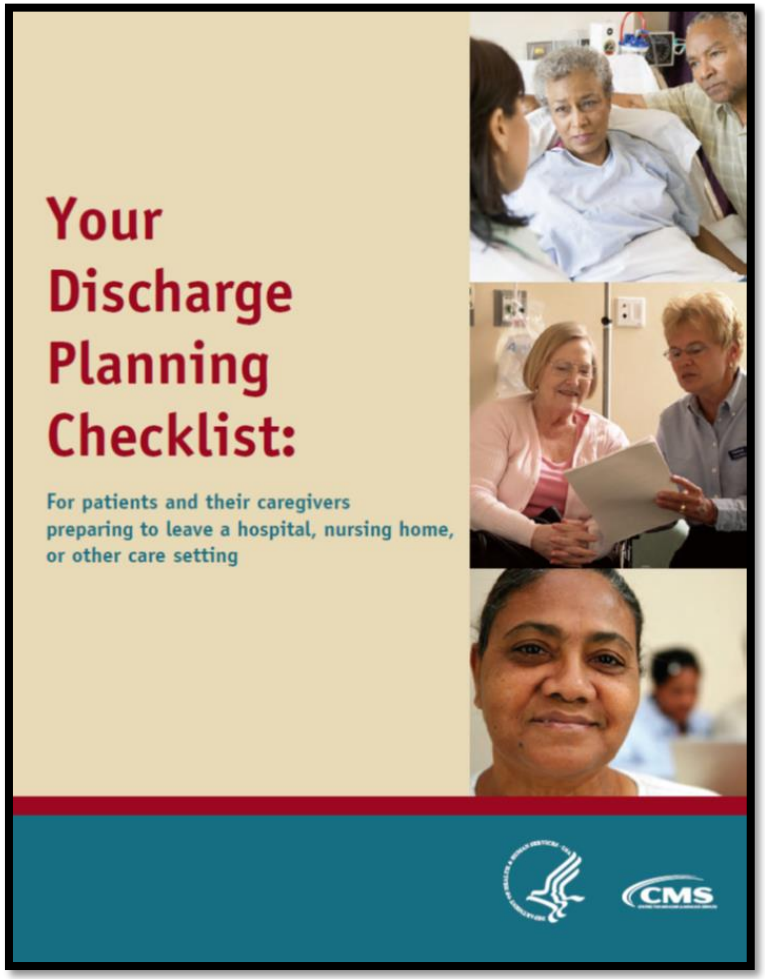
What transitional care services & processes do all patients benefit from?

IDENTIFYING A FAMILY CAREGIVER

- Who counts as family?
  - "Family" should be interpreted broadly.
  - Spouses and adult children are *most likely* to take on care, *but not always*. Often other relatives are involved.
  - Family members may or not be related by blood or marriage but are "fictive kin" or "families of choice," such as neighbors, church members, and others.
- Ask patient, "Who helps you with your medications?"
- May be more than one family caregiver
- Who is the primary learner?

https://www.nextstepincare.org/

HOW ARE YOU USING IT?



https://www.medicare.gov/Pubs/pdf/11376.pdf

If you're not already using it, make a plan to start

HOSPITAL ADMISSIONS RISK MULTIPLIER SCREEN (HARMS-8)

1. How would you rate your current health?
2. How many prescription medications are you taking?
    a) How often do you decide not to take your medications?
    b) How sure are you that you know the reason for taking meds?
3. Are you having any difficulty doing activities of daily living?
4. How often do you have trouble remembering or thinking clearly?
5. How many friends/relatives you could call on for help?
6. How confident are you that you can manage your conditions?
7. During the past 6 months, did you go to the emergency room?
    a) Do you think you will go to the emergency room again?
8. During the past 6 months, did you stay in the hospital?

Discharge Plan Checklist: (LACE score ≥11 suggests high risk for readmission)

- ❑ Presenting problem that precipitated hospitalization identified and shared with patient/ family/caregiver.
- ❑ Patient/ family/caregiver educated on primary DX and secondary DX.
- ❑ Patient/ family/caregiver given a written schedule of discharge medications and instructions on purpose and cautions.
- ❑ Preadmission and discharge medications reconciled and patient/ family/caregiver are aware of new medications, change in dose or frequency and medications that should be discontinued.
- ❑ Patient/ family/caregiver educated on anticipated problems and appropriate interventions relative to disease and symptom management.
- ❑ Patient/ family/caregiver have been educated on diet and activity.
- ❑ Patient discharged with a follow-up appointment within one week of discharge if physician concurs.
- ❑ Patient/ family/caregiver can identify primary care physician and consultants; knows about signs and symptoms that may develop, and when to call the physician or seek emergency medical care by calling 911.
- ❑ Patient/ family/caregiver can give a brief summary of discharge instructions when asked.

RN: Print and Sign Name: _____ Date: _____

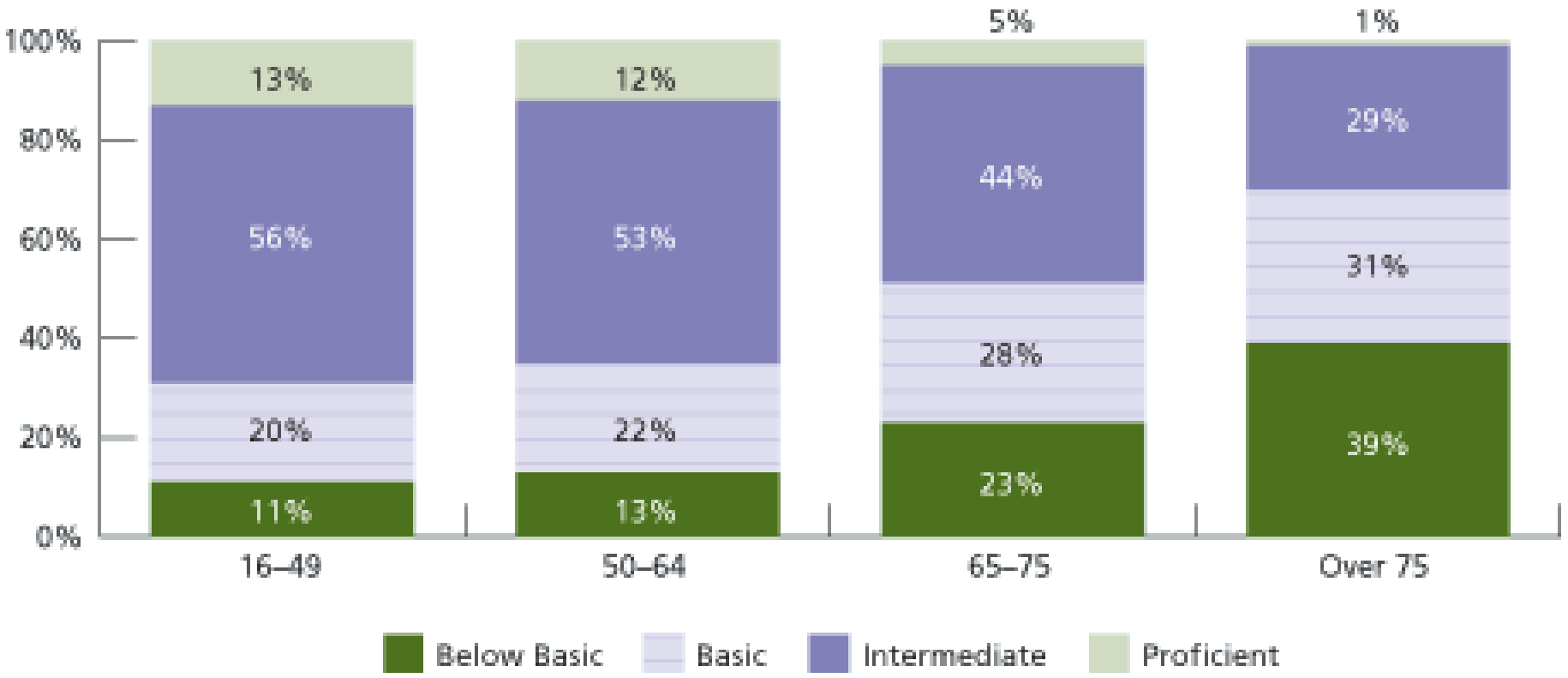
The 8Ps:
Assessing Your Patient's Risk For Adverse Events After Discharge

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	
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	

WHAT DOES THIS MEAN?

- There is a bear in a plain wrapper doing flip flops on 78 handing out green stamps.

ADULT HEALTHCARE LITERACY

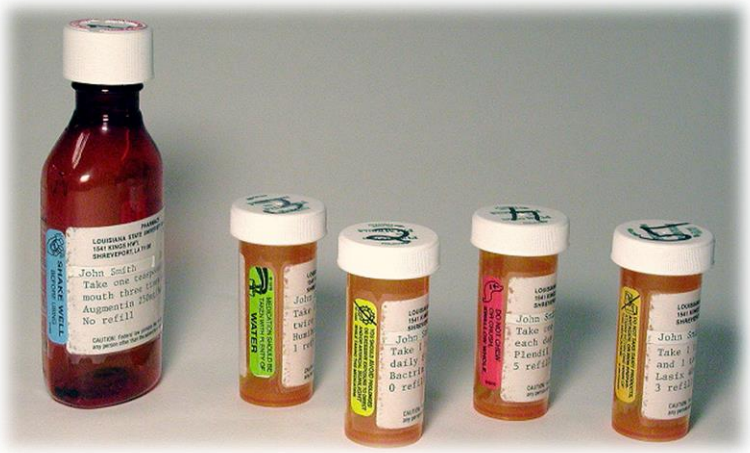


Source: U.S. Department of Education, Institute of Education Sciences, 2003 National Assessment of Adult Literacy

SIGNS TO LOOK FOR

- Frequently missed appointments
- Incomplete registration forms
- Not taking medications or not taking medications as prescribed
- Unable to name medications, explain purpose or dosing
- Identifies pills by looking at them, not reading label
- Unable to give coherent, sequential history
- Ask fewer questions
- Lack of follow-through on tests or referrals

MEDICATION CONFUSIONS IS COMMON



Davis TC , et al. Annals Int Med 2006

395 primary care patients in 3 states

- 46% did not understand instructions ≥ 1 labels
- 38% with adequate literacy missed at least 1 label

33%

1 out of 3 hospital readmissions are associated with medication-related problems (MRP) or complications.

NEHI Issue Brief, October 2012
Improving Medication Adherence and Reducing Readmissions
http://www.nacds.org/pdfs/pr/2012/nehi-readmissions.pdf

Frankl SE, et al. Am J Med 1991 Jun;90(6):667-74
http://www.ncbi.nlm.nih.gov/pubmed/2042681

CTM3

HCAHPS 23
During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.

HCAHPS 24
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

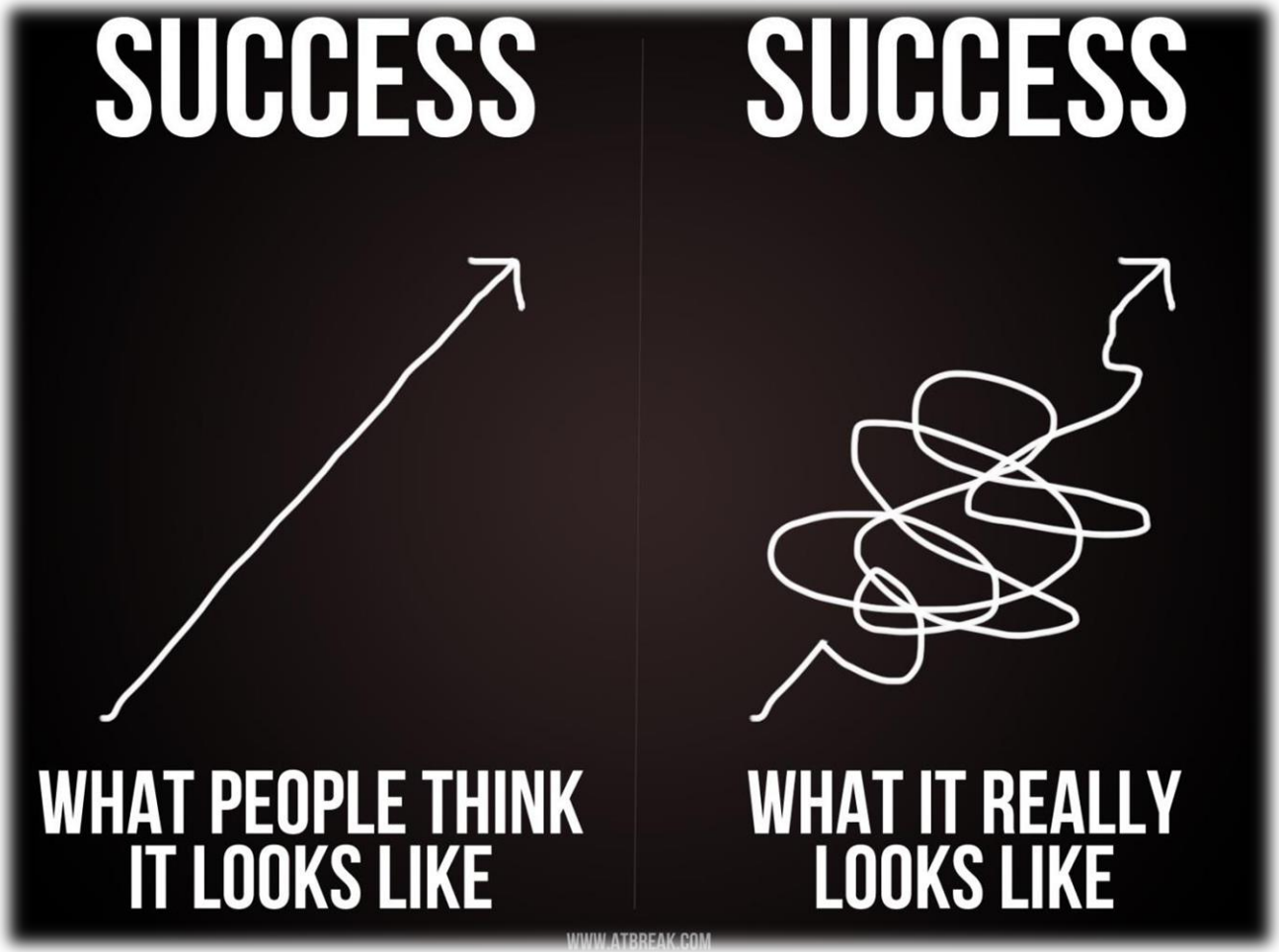
HCAHPS 25
When I left the hospital, I clearly understood the purpose for taking

How are you doing on question 25?

VPB

- HCAHPS questions are part of value based purchasing

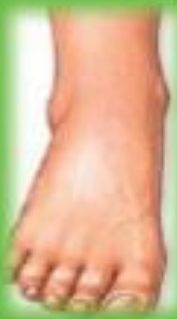
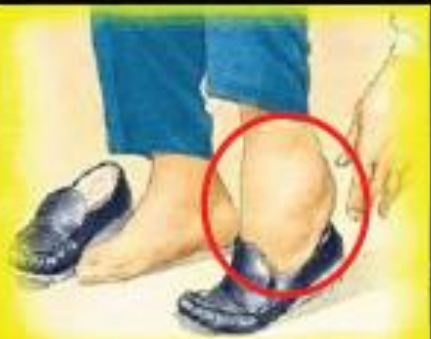
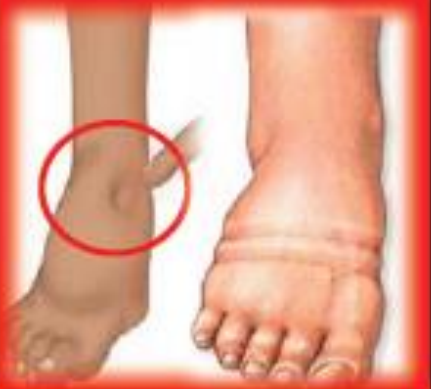
MEDICATION RECONCILIATION



WHAT YOU CAN DO

- Focus on “need-to-know” & “need-to-do”
- Use teach-back method
- Demonstrate/draw pictures
- Use clearly written education materials

自我監察心臟衰竭的症狀 Monitor My Heart Failure Symptoms

	呼吸 Breathing	水腫 Swelling	體重 Weight	採取行動 Action
好 Good				
注意 Caution			 1 天增 2 磅或 1 週增 3 磅 Gain 2 lbs in 1 day or 3 lbs in 1 week	
危險 Danger			 超過 3 磅!! More than 3 lbs!!	請送我到東華醫院 I NEED TO GO TO CHINESE HOSPITAL

AFTER HOSPITAL CARE PLAN

Sample After Hospital Care Plan (AHCP)

*****Bring This Plan to ALL Appointments*****

After Hospital Care Plan for:

Oscar Sanchez

Discharge Date: August 1, 2012

TRY TO QUIT SMOKING: Call Jon Doe at (555) 555-3344 at ABC Medical Center.

Question or Problem with this Packet? Call your Discharge Educator: (555) 555-2222

Serious health problem? Call Dr. Mark Avery: (555) 555-5555

EACH DAY follow this schedule:

project BOOST
Better Outcomes for Older adults through Safe Transitions

Patient PASS: A Transition Record

Patient Preparation to Address Situations (after discharge) Successfully

I was in the hospital because _____

If I have the following problems ...	I should ...
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

My appointments:

1. _____
   On: __/__/___ at __:__ am/pm
   For: _____
2. _____
   On: __/__/___ at __:__ am/pm For: _____
3. _____
   On: __/__/___ at __:__ am/pm
   For: _____
4. _____
   On: __/__/___ at __:__ am/pm
   For: _____

Tests and issues I need to talk with my doctor(s) about at my clinic visit:

1. _____
2. _____
3. _____
4. _____
5. _____

Important contact information:

1. My primary doctor:
   _____
   (____) _____
2. My hospital doctor:
   _____
   (____) _____
3. My visiting nurse:
   _____
   (____) _____
4. My pharmacy: _____
   (____) _____
5. Other: _____
   _____

I understand my treatment plan. I feel able and willing to participate actively in my care:

_____
Patient/Caregiver Signature

_____
Provider Signature

____/____/_____
Date

Other instructions: 1. _____
2. _____
3. _____

VALIDATE UNDERSTANDING, TEACH-BACK

Chunk & Check

TEACH AND PRACTICE TEACH-BACK

POST DISCHARGE PHONE CALLS

Who should you call?

Who will make the calls?

What will you do with the information you learn from your calls?

Tips

- Set expectations
- Validate phone number

WHAT CAN WE DO DIFFERENTLY?

1. Improve patient engagement
   - Listen more- what are the barriers?
   - What works best for you?
2. Identify patient goals
   - What matters to you? NOT What's the matter with you?
3. Modify educational materials and approach
   - Less is often more- what are the vital few?
   - Water pill vs Lasix
   - Validate understanding through the use of teach back
4. Build self-reliance skills, e.g.
   - What to say when calling the doctor's office
   - Setting up systems for medications
5. Motivational interviewing skills
6. Celebrate small successes

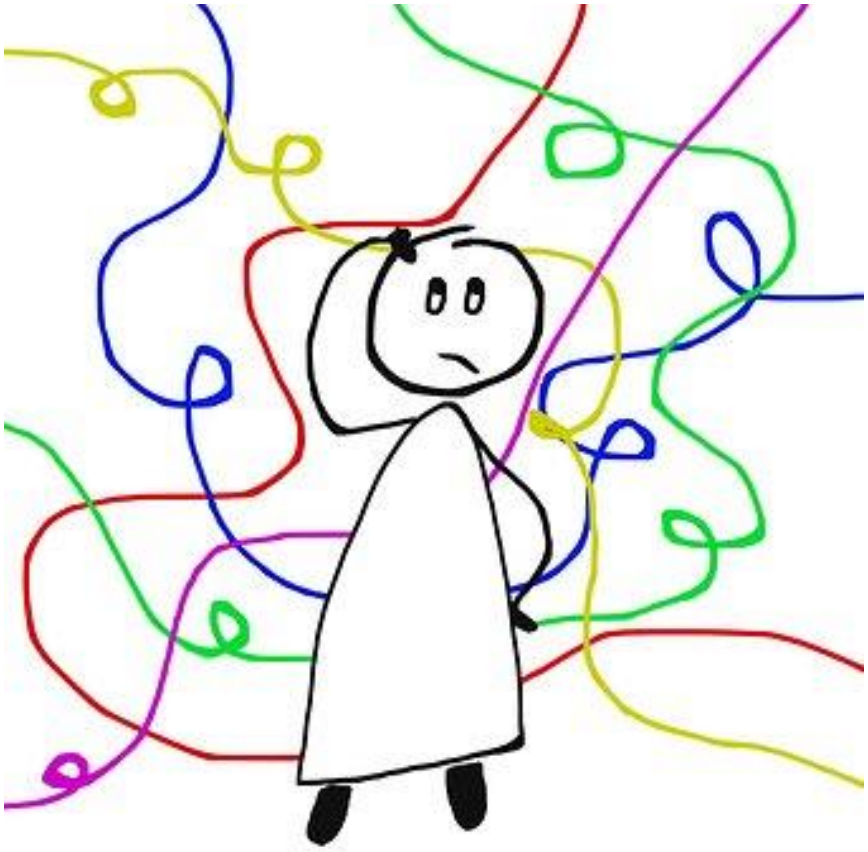
KEY QUESTIONS?

How do you identify the learner and understand their preferences?

How do you understand the patient's goal(s) and specific risks and develop a plan to mitigate the risks?

How do you assess for health literacy, provide clear and understandable instructions, including a medication list, and validate understanding through teach-back?

How do you f/u to make sure your patients got home?



DRIVERS AND COMMITMENTS

What key drivers do you need to work on?

What ideas did you like?

What idea will you test in your organization?

- Who?
- By when?