Quality Resource Brief

TRIPLE AIM ACHIEVEMENT • AUGUST 2015

The Missouri Hospital Association will periodically release tips and tools to assist hospitals in achieving the Triple Aim – better health, better care, lower costs. These resources, and many more, can be accessed at www.mhanet.com/strategic-quality

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Patient and Family Care Transitions Upon Discharge: Ensuring Success Together

Hospitals challenged by Medicare and other payers to reduce the length of hospital stays are often discharging patients sooner than patients and families expect. At the same time, through the Hospital Readmissions Reduction Program, hospitals are under pressure to reduce preventable readmissions among five clinical conditions. Hospitals are faced with the task of preparing patients and families to provide ongoing care at home and by ensuring they understand how to self-manage the clinical condition. Unfortunately, patients often go home, where with little or no professional assistance, family members must provide complex and difficult care. Not only must spouses and adult children help with activities such as bathing, feeding and lifting their loved ones; they also must take on complicated medical care that would otherwise be handled by highly-trained nurses.

A 2011 survey by AARP, Inc., and the United Hospital Fund found that half of family caregivers perform medical tasks. Nearly 80 percent manage medications, more than one-third change dressings and perform other wound care, and more than one-quarter use incontinence equipment — often with little to no training or confirmed understanding.[5,8] It is not surprising, then, that 1 in 5 discharged patients experiences a post-discharge adverse event, and 1 in 4 discharged patients are readmitted within 30 days as a result of poor transition from hospital to home.[3]

Much work remains for hospitals to provide a continuum of care through transition. **Even replacement of the word "discharge" with "transition" in hospitals' vocabulary reflects that the hospital care team and the patient and family do not end their relationship when the patient leaves the hospital.** This issue brief highlights the most common failure points associated with hospital discharge, offers practical tools and effective strategies for hospital staff and caregivers, and shares valuable insights from the patient perspective.

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TYPICAL HOSPITAL-TO-HOME TRANSITION FAILURES[2]

Discharge Planning Process

- failure to actively include the patient and family in identifying needs, resources and planning for discharge
- lack of explicit roles and responsibilities identified for care providers
- discharge planned when optimal staffing is not available or assigned to the least experienced member of the care team
- unrealistic optimism of the patient and family to manage at home

Discharge Plan Content

- written discharge instructions that are confusing, contradictory to other instructions or not tailored to a patient's level of health literacy or current health status
- lack of an emergency plan, including the telephone number a patient should call first
- outdated medication plans or plans not reconciled with medications that the patient has at home

Care Coordination for Discharge

- lack of coordination and information sharing between the facility and community care providers, including primary care physicians
- patient returns home without essential equipment to self-manage (scale, supplemental oxygen)

Health Literacy/Communication

- patient/family education occur only during and at time of discharge
- patient/family too intimidated to ask clarifying questions or for additional instruction
- patient is not provided with a comprehensive discharge plan that they can understand and use to follow through with discharge instructions

BEST PRACTICE STRATEGIES FOR SAFE DISCHARGE HOME

Effective Discharge Planning Tools

Discharge from hospital to home requires the successful transfer of information from clinicians to the patient and family to reduce adverse events and prevent readmissions. Engaging patients and families in the discharge planning process helps make care transitions safe and effective.

The Agency for Healthcare Research and Quality endorses the IDEAL Discharge Planning Model and Toolkit, which highlight the key elements of engaging the patient and family in discharge planning, and include a discharge planning checklist for clinicians.[1]

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:

- describe what life at home will be like
- review medications
- highlight warning signs and problems
- explain test results
- 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.

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DISCHARGE PLANNING

The Voice of the Patient[6]

After her own bout with illness and an intimidating inpatient experience, Jessie Gruman, Ph.D., Founder and President of the Center for Advancing Health in Washington, D.C., and author of *Aftershock: What to Do When You or Someone you Love is Diagnosed with a Devastating Diagnosis*, offers the hospital experience from a patient's perspective.

Invite and expect our participation from the get-go.
"From the moment we enter the hospital, we need to hear messages of welcome and inclusion from our clinicians and our institution: 'You have a role to play in your recovery; we will work on this together.' Include us and our family caregivers in bedside shift reports. It's easy for harried clinicians to just go through the motions of each of these. And, it's easy for many of us to observe such discussions through the hazy lens of our pain or from behind the protective shield of our non-expertise. Unless we are specifically invited to participate in ways we can understand, many of us will remain passive spectators."

Keep us informed.
"Knowing that 'today we are going to take out the catheter' helps us prepare for our day and gives us responsibility for tracking follow-through. The more familiar we are with the drugs and procedures we are receiving, the better we will understand the risks and requirements of our illness. This can help us make sense of the rhythms of our care in preparation for taking it on ourselves when we get home."

Teach us.
"Despite feeling horrible, most of us really want to go home as soon as we can. The physical activity, respiratory therapy and pain assessment we must do as inpatients are often prerequisites for our release. Teach us while we are in the hospital why they are important and how and when to do them. This builds skills we need and sets the expectation that we'll continue them when we are on our own. Ask us about the status of each during bedside change of shift meetings or rounds."

Start early in our stay.
"Our capacity for learning complex new concepts when we are ill enough to be hospitalized is limited, as is the capacity of our worried, distracted, busy family. We need help focusing on the few critical changes, practices and procedures that are most important to pay attention to — temperature, weight, intake and output. Teach-back programs that focus on the major tasks of self-care and associated danger signs are far more effective than the old pamphlet-on-the-tray-table approach.

Shifting our orientation from one of passivity to one of active involvement in our care is difficult for most of us when we are well. And it is *really* tough when we are sick and under stress. Many of us are at our wits end when we are in the hospital — intimidated by the technology, frightened that we or our loved one might die or angry at what we experience as inattentive or unsafe care. Help us be involved and help us understand."

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Strategies for a safe and effective discharge transition may consist of written, visual or recorded discharge plans. As the complexity of care increases, the population ages and adequate home care resources become harder to obtain, the needs of family caregivers must be addressed. This work can start at the bedside when families are present.[7] The Robert Wood Johnson Foundation has several patient-centric discharge tools available. Figures 1-3 are examples of these tools that providers may utilize to better ensure effective care transitions.[4]

Figure 1: My Care Transition Plan Form, Robert Wood Johnson Foundation

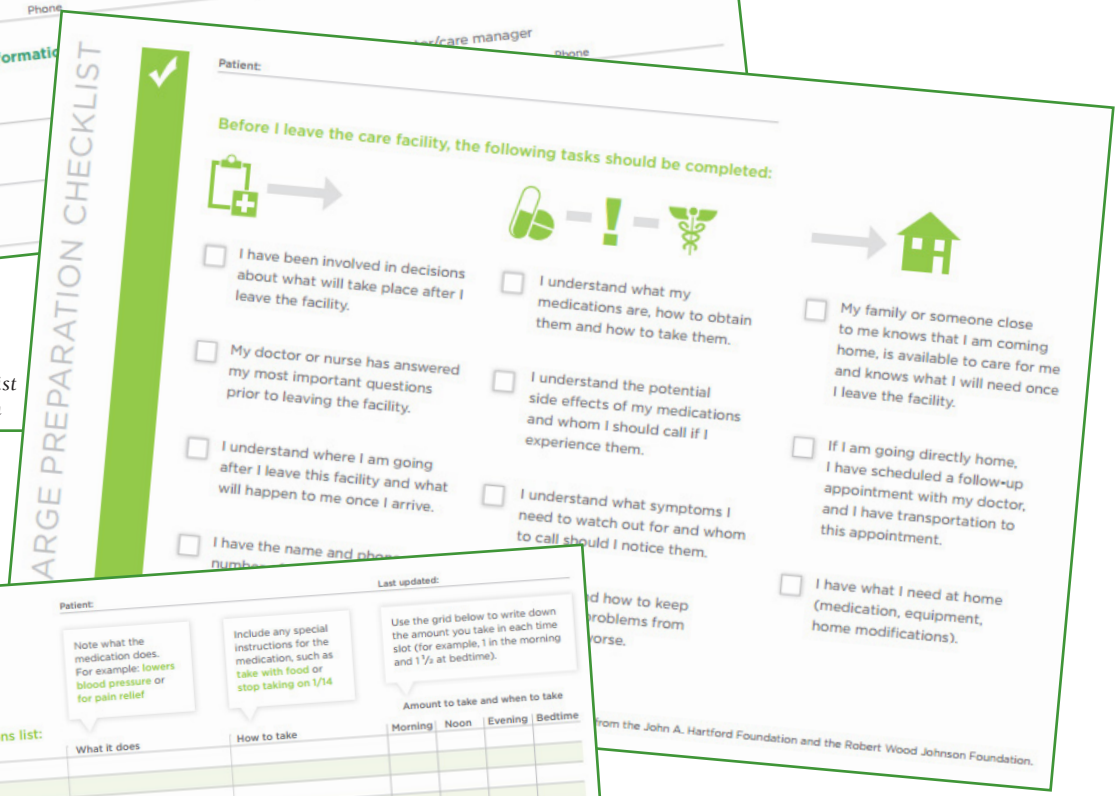

Figure 2: Discharge Preparation Checklist Form, Robert Wood Johnson Foundation

Figure 3: My Care Transition Plan Medication List Form, Robert Wood Johnson Foundation

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SUGGESTED CITATION

Nicholson, G. & Williams, A. (2015, August). *Patient and family care transitions upon discharge: Ensuring success together.* Missouri Hospital Association.

TRANSITION PLANNING TO PREVENT READMISSIONS

The RARE campaign[2] — Reducing Avoidable Readmissions Effectively — created by the Minnesota Hospital Association, discusses five key drivers as best-practice strategies to ensure patients and families have a high rate of success upon transition to self-management. A major driver of hospital readmissions is thought to be the result of the fragmentation of care in the health care system. Ensuring these key criteria are addressed effectively and the discharge information is provided in a patient-friendly layout and format is recommended.

5 KEY AREAS KNOWN TO REDUCE AVOIDABLE READMISSIONS

1. **Comprehensive discharge planning**
2. **Medication management**
3. **Patient and family engagement**
4. **Transition care support**
5. **Transition communications**

CONCLUSION

Health care providers should make engaging patients and families in transition planning a priority to not only help reduce the rate of preventable readmissions, but also provide better transitions of care to other providers, increase the success of self-management practices and provide for the increased health of the population. Patients and families have a central role in achieving the Triple Aim of better care, better health and lower costs. Engaging patients in more circular, overlapping, and continual supportive care transitions is key to improving care, particularly for the medically and socially complex patient.[9]

REFERENCES

[1] IDEAL Discharge Planning Tools: http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy4/

[2] Reducing Avoidable Readmissions Effectively: www.rarereadmissions.org/areas/compdischarge.html

[3] Robert Wood Johnson Discharge Planning Checklists: http://www.rwjf.org/content/dam/farm/toolkits/toolkits/2013/rwjf404048

[4] Half of Family Caregivers are Providing Nursing Services: http://howardgleckman.com/2012/10/half-of-family-caregivers-are-providing-nursing-services/

[5] Hospital Discharge Planning: Helping Family Caregivers Through the Process: http://www.caregiving.org/data/dischargeplanners.pdf

[6] Supporting Family Caregivers: Communicating With Family Caregivers: http://nursingcenter.com/cearticle?tid=1271946

[7] Home Alone: Family Caregivers Providing Complex Chronic Care: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/home-alone-family-caregivers-providing-complex-chronic-care-in-brief-AARP-ppi-health.pdf

[8] Next Step in Care's "What Do You Need as a Family Caregiver?": http://nextstepincare.org/Provider_Home/What_Do_I_Need/

[9] Roberts, S., Crigler, J., Ramirez, C., et al. (2015, July/August). Working with socially and medically complex patients: When care transitions are circular, overlapping, and continual rather than linear and finite. *Journal for Healthcare Quality, 37*(4), 245-265.

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