Care Transitions

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

COMMUNICATION

During Admission Rounding

"You are the expert in your care. We will be teaming up to use your knowledge and ours to make sure you are totally comfortable with the different aspects of your care you will be responsible for at home. If at any point during your stay you feel that something was not clear or will not work for you, we want you to stop and ask that person to clarify their meaning, discuss it, or show you again."

During Patient Rounding

"Please tell me the different steps you will need to take with your care once home."

[Patient answers]

"You seemed a little unsure about when to take your medications; let's review that timeline again."

During Discharge Rounding

"Would you mind showing me what your home care plan is, and talk about who will be helping you with each step?"

PROCESS

Use the Teach Back Method

- Ask patients to "teach back" any critical information that is shared with the patient and/or their family members to validate our communication and their understanding of the information

It's a Team Effort

- Create goals for Care Transitions improvement with Social Work and Case Management teams. Thoroughly review all potential barriers (especially social) to the patient's home care responsibilities and medication regimen
- Develop relationships with community not-for-profit agencies who can help strengthen your patient population's health literacy and may be able to partner with the patient once they are back home

Give Them Options

- Have multiple teaching methods and modes of educating the patient depending upon their learning style/ preferences (phone, video, paper, websites, etc.)