PRC Best Practice Tips

Care Transitions

Survey Questions:

- Care Preferences: *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. [Strongly Disagree, Disagree, Agree, or Strongly Agree]*
- Responsibilities: *When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. [Strongly Disagree, Disagree, Agree, or Strongly Agree]*
- Medications: *When I left the hospital, I clearly understood the purpose for taking each of my medications. [Strongly Disagree, Disagree, Agree, or Strongly Agree]*

Tips for Impacting Your Patients' Care Transition Perceptions:

Care transitions measurement was added to the HCAHPS survey in January 2013, and became part of Value-Based Purchasing as of 2016 patients. One of the goals for this added measurement is to lower re-hospitalization rates, by ensuring patients have the proper education and understanding of their responsibilities, involvement, and steps to take after leaving the hospital.

The hospital's responsibility is to enable the patients with the information needed to make this transition smooth, of which effective communication is key. At the same time, we have to keep in mind a hospital stay is often a very overwhelming experience for patients, and a time of vulnerability. This can produce barriers for this communication. Some patients may not feel ready to leave. Some patients may not understand or even have all of the answers to why they were in the hospital or what is to come, at the point where it is time to leave. With a hospitalization, patients are often overwhelmed with what they are experiencing both physically and mentally, and not in the best state to receive, remember, or proactively ask necessary information. Hospitals need to help empower their nurses and providers with the tools to elicit that proper communication.

Begin the care transition conversation early in the patient's stay

With increased understanding, patients should feel more at ease, and more likely to comply with their responsibilities, medications and steps to take after leaving, leading to better outcomes. There is a lot of information to cover with patients, which can be overwhelming if handled only at the time of the discharge process. Take advantage of the multiple touch points you have with patients throughout their stay to communicate about these items. Best practice is preparing the patient for that ultimate departure, beginning much earlier in their stay, as follows.

- Provide a notepad at the patient's bedside, from the start of care. Encourage the patient to note questions or reminders as they come to mind. Be sure to address those with the patient during rounding, and before they leave.
- Before sharing education/updates, ask the patient first if they have questions. This helps clear their mind to allow them to absorb your explanations better.

- For surgical patients, a short class prior to admission can help the patient better prepare for surgery and recovery, to begin the discharge education piece even before the hospital stay.
- Family and/or another caregiver may be involved in the patient's care after leaving the hospital, so involving them in the communication during the stay is best.

Multiple and clear communication methods

- Ask the patient which method of communication is their most preferred, for focus. However, don't rely solely on written or verbal communication. Use each as a supplement to the other.
- Many caregivers are involved in a patient's stay; keep these tips in mind:
    - Patients see us as one organization for their whole experience, not in silos by department.
    - Create intentional coordination efforts between departments, and manage up! Speak genuine praises about the other departments, providers and staff involved in the patient's care. Set positive and clear expectations for the patient about them, so they have more of a comfort level for what to expect.
    - Create safe handoffs between shifts and departments, such as via bedside shift reporting.
- For very important information, include it up front in the information conveyed to the patient and consider supplementing those important points in written form as well. Also, for especially important documents in a folder, print them on brightly colored paper; do this sparingly though so they stand out among the rest. Patients have so much going through their mind during their visit, that having important information written and easy to find for later reference is very helpful.
- Keep written and verbal information very simple (3rd to 6th grade level). Medical terms that seem so familiar to providers can seem very overwhelming and unclear to patients; try to simplify as much as possible so explanations are given in a way the patient can comprehend.
- All-in-one Discharge Form: Include a one-page (even if front & back) document in the discharge packet on a bright colored-page that the patient can have handy to reference and bring to follow-up appointments that has the most important information all in one place. For example, medications and short instructions, symptoms to look out for that would necessitate a return to the hospital, when follow-up tests and/or follow-up appointments are scheduled. This would not replace the other, more detailed, documents in the discharge folder, but rather a summary of the key points all in one place.

Care Preferences

- Keep interactions patient-centered….start with the patient, end with the patient.
- The patient is part of the care team. Talk with them not to them.
- Ask what their preferences are. If their preferences are not possible, acknowledge, explain why, and provide alternate options. Sometimes it isn't as much about the outcome, as it is about talking through it together and having a clear understanding of the "why" behind decisions.

- Schedule a time for family conferences to take place from the patient's room, so that family/caregivers can be phoned in for the discussion. This keeps everyone on the same page, and eliminates trying to get in touch separately.
- If family and/or a caregiver is visiting a patient, ask the patient what their preference is regarding when we discuss their care plans after leaving; would the patient like family present or would the patient prefer we communicate individually with just him/her?

Responsibilities

- Patients often want to know "what is next," so as part of the explanation of their responsibilities, discuss what to expect after leaving the hospital, scheduling of appointments, etc. For example, if a follow-up diagnostic test is needed for the patient, explain who they will schedule that with, how they will find out the results, who they will find out the results from, what to expect that the tests or treatment will be like, etc.
    - Suggest to the patient and/or help to schedule follow-up appointments before the patient leaves the hospital.
- Discuss who is going to help the patient when they go home if needed.
- Discuss what symptoms would necessitate going back to the hospital or ER.
- Teach-back – Have patient repeat back what you have explained to make sure he/she clearly understands what was discussed.

Medication

- Medication cards
    - Determine which medications are most commonly prescribed for patients in your department. Create cards specific to those most commonly prescribed.
        - Include on the card:
            - Name of medication
            - What the medication is for
                - Especially if the patient is receiving a new medication, talk about what the medication is for. This way the patient understands the *benefit* of the medication and *why* the doctor prescribed it, and keeps the conversation from otherwise focusing only on the negative (i.e. side effects).
            - Most common side effects
                - Most medications have a laundry list of side effects. Communicate about the most important ones.
        - Use the card as a supplement to conversation
            - Provide the appropriate reference card(s) to the patient, as you have the conversation with the patient about the medication.

- If there are differences in medications from what the patient has been taking, or confusion, have a pharmacist meet with the patient before discharge.
- Knowledge of medication(s) patient is already taking: If the inpatient visit was scheduled ahead of time (such as a surgical patient), request the patient either bring in their medications, or a list of them, so the care team is fully aware of what they are already taking. If it is an unscheduled visit, try to obtain this information from family or the patient's doctor, sometime during the stay.
- Have a conversation with the patient about their medication preferences. Some patients may prefer medication over other comfort measures, while other patients may prefer to avoid medications when possible. For those patients, it is especially important to explain the purpose and importance of each medication, to increase their likelihood of compliance.
- Timing of taking medications – Clarify and document for the patient. Discuss with the patient if he/she needs any assistance for compliance in taking their medication.

To track your patient perception scores on these questions:

- Visit www.prceasyview.com, for ongoing updates.
- PRC's "EasyView to You" feature can email your desired reporting view of the scores to you on a schedule of your preference.
- For assistance, contact PRC's PRCEasyView® Support Team at 1-800-547-9584.

Thank you for partnering with PRC!