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These presenters have nothing to disclose

Developing Post-Hospital Follow-Up Care Plans and Real-time Handover Communications

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September 28, 2015

Session Objectives

Participants will be able to:

- Identify failures in current processes to arrange post-transition care from the literature and experience
- Describe opportunities for identifying patients who are at moderate and high risk for readmission
- Identify useful tips and processes for handover improvements and for effective follow-up to keep patients safe after acute care
- List tips and techniques for partnering across the continuum of care to get results.

Assume one of the following roles :

Patient

Sending Hospital dept.

Hospitalist

Home Care

Outpatient Social Worker

Caregiver

Receiving SNF

Medical Director SNF

Clinic Physician

Community Serv. Agency

Describe your ideal transition into the new setting…….

(what would you need or want in that transition?)

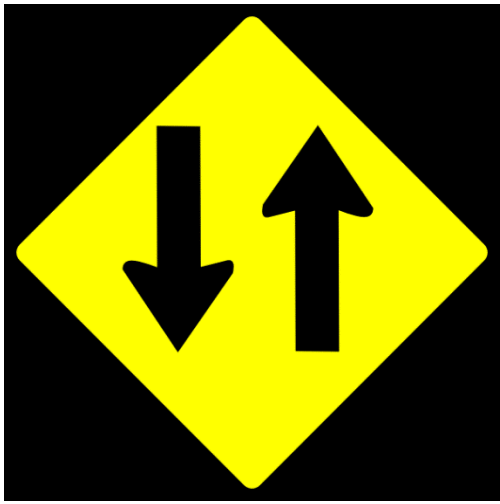
Communication Is a Two Way Street

How often have you reached out to cross-setting partners to get their input.

Did you meet by phone or face-to-face?

Who did you meet with?

What surprised you?



STate Action on Avoidable Rehospitalizations

An initiative of The Commonwealth Fund & the Institute for Healthcare Improvement

How-to Guide:

Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations

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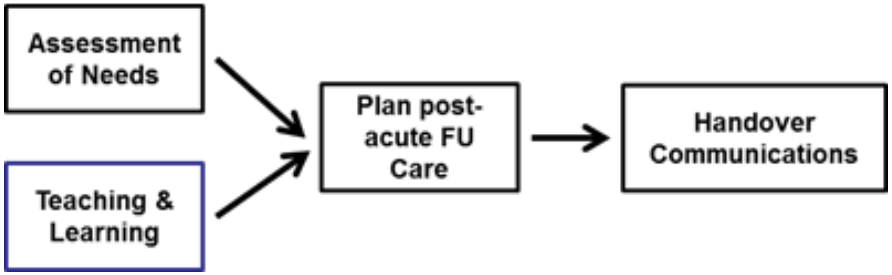
Hospital



Prompts frequent monitoring
In the post-acute continuum

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How Might We….

"….effectively communicate the plan of care (based on the assessed needs and capabilities) to the patient/caregiver and community-based providers of care?"

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Simply

- What do we know about the patient/caregiver that will help the next level provide the needed care in the transitions?
- How will we communicate that?
- What are Sender Role vs Receiver Roles?

Identifying Opportunities

- Observe a discharge instruction encounter and/or plan of care processes
- Visually display the patterns of return to hospital within 30 days; what questions arise?
- Utilize your Cross Continuum Team to
  - review cases and determine appropriate actions
  - interview patients on what brought them to the hospital
  - develop communication protocols and tools

Observe Current Discharge Processes

Observation Guide: Observing Current Discharge Processes

Observe three patients on the day of discharge (i.e., last day of the hospital stay). Spend one to three hours with each patient and family members to discover what went well, what didn't work as planned or predicted and opportunities for improvement.

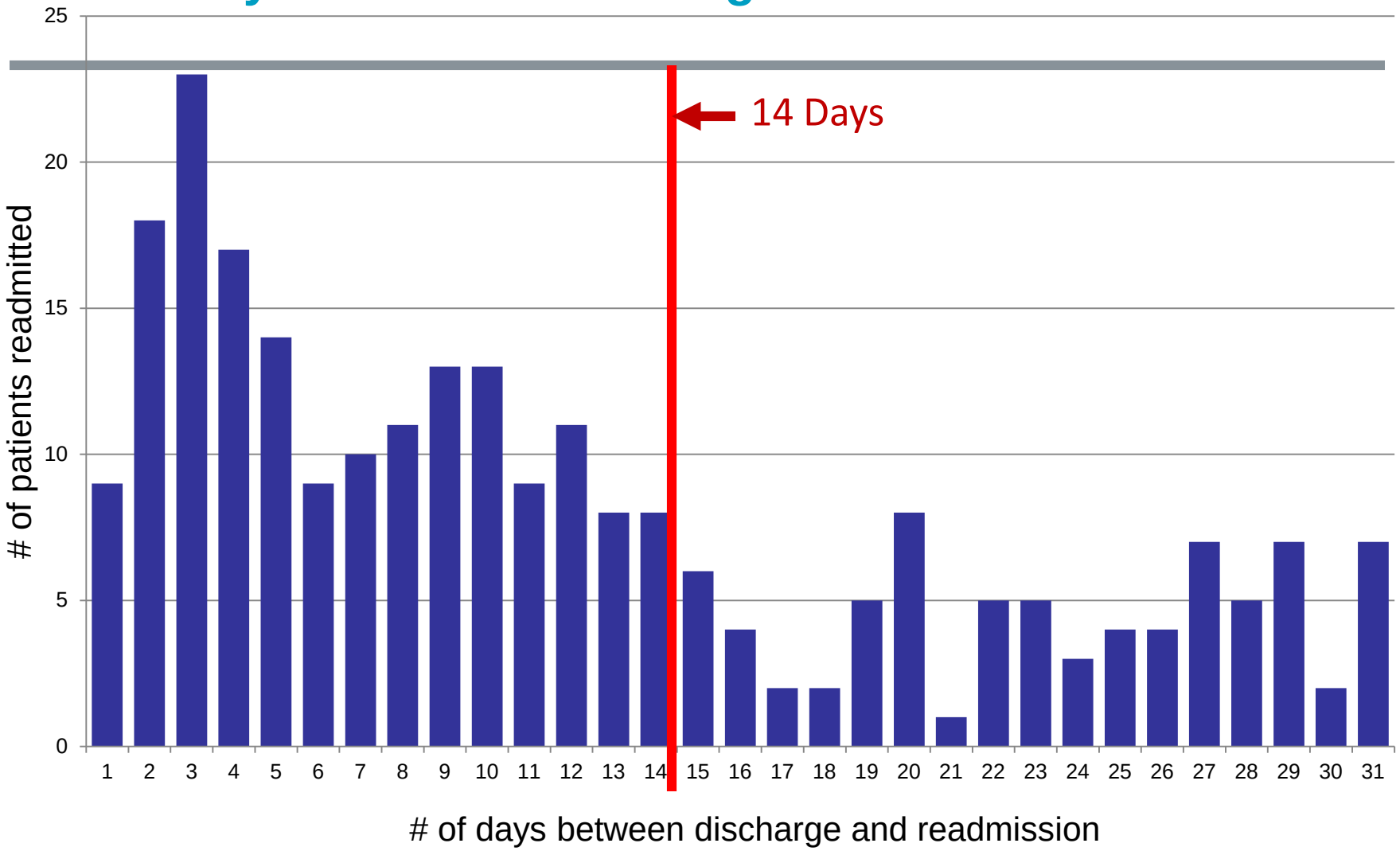
What do you predict you will observe?

Did the care team member(s)…	Patient # 1		Patient # 2		Patient # 3	
	Yes	No	Yes	No	Yes	No
Assess the patient's clinical status and determine readiness for discharge?	☐	☐	☐	☐	☐	☐
Reconcile medications prior to completing instructions for the medication regimen prior to discharge?	☐	☐	☐	☐	☐	☐
Initiate plans to ensure that the patient has the essential supplies and equipment for identified post-acute care needs?	☐	☐	☐	☐	☐	☐

How-to Guide page 114

Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.

Frequency of Readmissions by Number of Days Between Discharge and Readmission



Key Changes for Real-time Handover

- **Identify Risk Level:** Review daily the patient's medical and social risk and/or barriers that would contribute to a readmission.
- **Customize the Plan of Care:** with real-time critical information to the patient and next clinical care provider(s).
- **Arrange Timely Follow-up Care:** initiate clinical and social services as indicated from identified post-hospital needs
  - Determine capabilities of the patient/caregiver and the post acute services to meet the identified needs

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Risk


Financial Driven Risk
High Risk
No Social Support
Vulnerable
Low Risk

Assess Risk of the Transition

- Build risk-assessment into clinicians workflow in order to identify patients/caregivers at risk
- Number of risk-assessment tools are reported in the literature (BOOST, LACE, IHI, Transitional Care Model (TCM), etc.)
- Inconsistencies regarding which characteristics and/or variables are most predictive of patients who are at risk for readmissions
- Equip clinicians with the training and tools to match patients to the most appropriate level of care.

Eric Coleman, MD: Identification of Patients at Risk for Admission

- Ideally a risk tool would not only identify those at high-risk for readmission but more precisely those who have modifiable risk.
  - In other words, risk tools should be aligned with what we understand about how our interventions work and for which patients our interventions work best
- In the case of heart failure, we should be careful to not assume that the primary readmission for heart failure is after all…the heart
  - Low health literacy, cognitive impairment, change in health status for a family caregiver, and more may be greater contributors than left ventricular ejection fraction

Eric Coleman, MD: Identification of Patients at Risk for Admission (cont.)

- Asking the patient to describe, in her or his own words, the factors that led to the hospitalization and where they need our support may provide greater insight into risk for return-
- What is the real story from patients perspective?
- Non-patient factors may have a larger role in readmission rates, such as the health care system and access

IHI's Approach: Assess the Patients Medical and Social Risk for Readmission

High-Risk	Moderate-Risk	Low-Risk
• Admitted two or more times in the past year • Patient or family caregiver is unable to Teach Back, or has a low confidence to carry out self-care at home	• Admitted once in the past year • Patient or family caregiver is able to Teach Back most of discharge information and has moderate confidence to carry out self-care at home	• No other hospital stays in the past year • Patient or family caregiver has high confidence and can Teach Back how to carry out self-care at home

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High-Risk	Moderate-Risk	Low-Risk
Post-acute Follow-up Care: Prior to Discharge		
• Schedule a face-to-face follow-up visit within 48 hours of discharge. Assess whether an office or home health care is the best option for the patient. • If a home care visit in 48 hours, also schedule a physician office within 5 days. • Initiate intensive care management as indicated (if not provided in primary care or in outpatient specialty clinics • Provide 24/7 phone number for advice about questions and concerns. • Initiate a referral to social services and community resources as needed.	• Schedule a follow-up phone call within 48 hours of discharge and a physician office visit within 5 to 7 days. • Initiate home health care services (e.g. transition coaches) as needed. • Provide 24/7 phone number for advice about questions and concerns. • Initiate a referral to social services and community resources as needed.	• Schedule follow-up phone call within 48 hours of discharge and a physician office visit as ordered by the attending physician. • Provide 24/7 phone number for advice about questions and concerns. • Initiate referral to social services and community resources as needed.

Customized Plan of Care

- Develop one comprehensive assessment and plan of patients post-acute care needs that integrates input from all members of the care team
- Make sure each member of the care team is clear about what information they must bring to the assessment and plan
- Consider patients: Preferences, Capabilities, Activation Level
- Change the focus on daily patient care rounds to include a discussion on current site but anticipating needs for next site
- Develop Bidirectional dialogue and collaboration between sender and receivers

Include the Patient's Perspective

Ask patient/caregiver:

- *"What matter most to you during this transition?"*
- *"What are your concerns or worries about going home or to the next care setting?"*
- *"Who do you want involved in your transition (your Support person)?"*

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Proposed Agenda: Patient Care Rounds

- Reasons for this admission? Are health care teams' and patient's/caregiver's goals in sync?
- What needs to happen during this hospitalization?
- What post-acute plan of care will meet the patients'/ caregivers' level of activation and comprehension of the plans? (Using Teach Back)
- Routinely ask: "what is the likelihood that this patient will be readmitted in the next 30 days?"
  - If the likelihood is high, why?
  - What services can be put in place to mitigate potential problems?

Key Elements in Transitions of Care

- Ensure that the patient and caregivers are present for discharge instructions
- Provide both the patient and caregiver a copy of the written discharge instructions
- Use Teach Back in your discharge instructions
- Highlight important points in the patient's d/c instructions
- Provide instructions that give them actions of what to do
  - Follow-up care, list of reasons to call for help and phone numbers for emergent and non-emergent questions.
  - What to expect when they return home and medication instructions

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Timely Follow Up Care

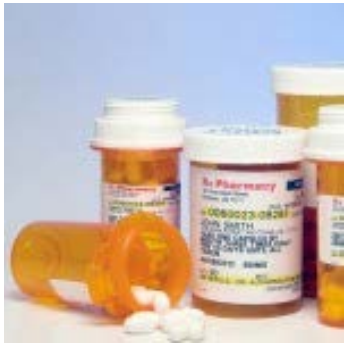
If the patient is transitioning home and will be receiving care in primary care office or specialty practice:

- Ensure timely and action oriented discharge summary that arrives prior to the patient's visit
  - Final reason for hospitalization
  - Recommendation for follow-up
  - Pending studies needing attention
- Arrange for access to patient discharge instructions in the office practice

Our Most Formidable Challenge

Year after year we try to improve med rec

However, gains have been modest



Not due to lack of trying

Why do you think medications represent our most formidable challenge?

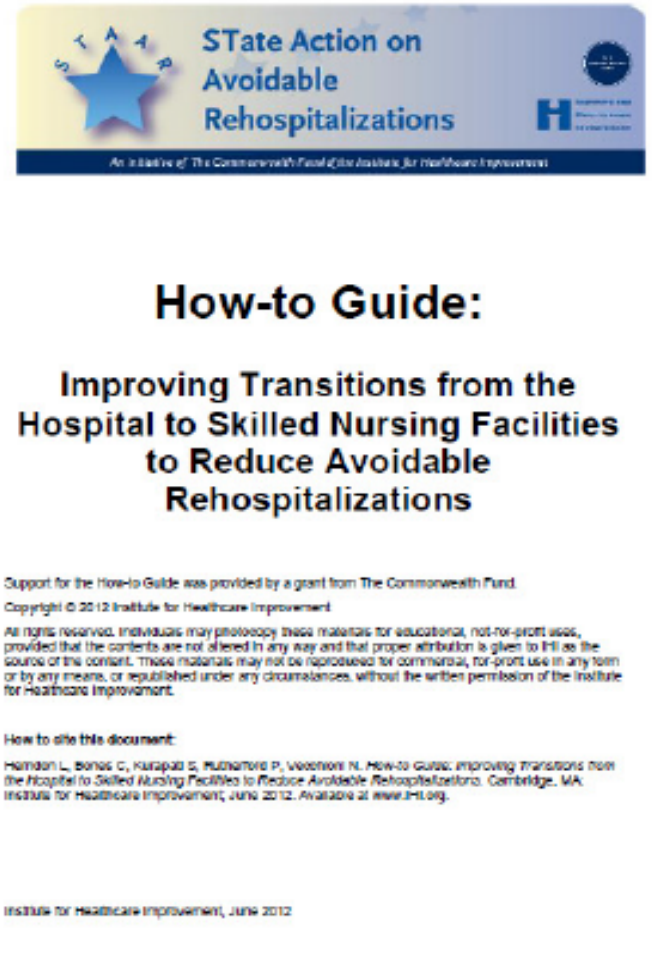
Medication Discussion with Patient/Family Caregiver

- Can they:
  - Read their medication labels?
  - Afford the necessary medications and foods?
  - Get to a pharmacy?
- Encourage patients and families to use a tool or document that does not require reliance on memory
- Discuss the role of Retail Pharmacy in their care

Warm Handover to Community Partners

Written handover communication for the patient at risk is insufficient: direct verbal communication allows for inquiry and clarification

Transition to Home Health Care, Long-term Care, Skilled Nursing or Other Community Settings



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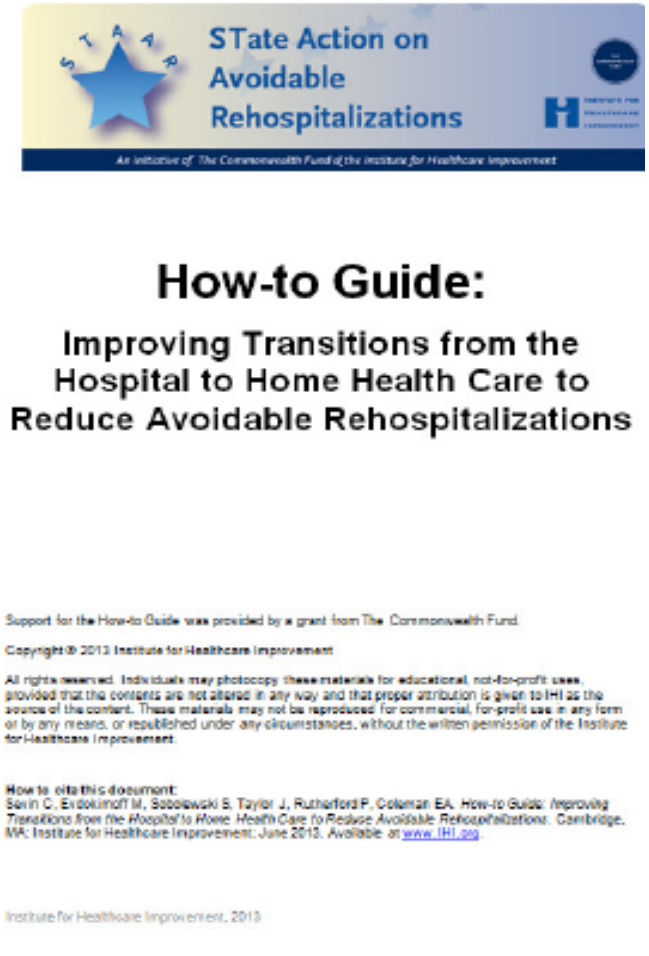
Institute for Healthcare Improvement, June 2012



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Institute for Healthcare Improvement, 2013

Transition to Home Health Care, Long-term Care, Skilled Nursing Facility or Other Community Settings

- Consider establishing HHC, SNF or LTC liaisons that are based in the hospital (ex. HHC liaison helps MDs determine qualifications for HHC)
- Work with liaisons and community partners to standardize critical information to be included in handover detail

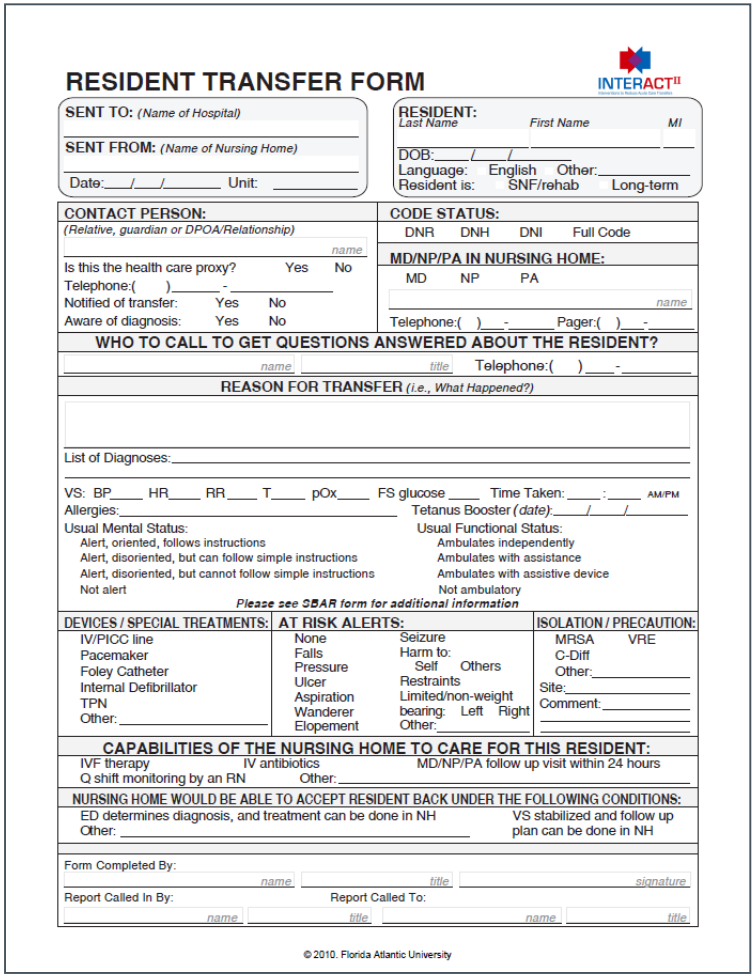
Transition to Home Health Care, Long-term Care, Skilled Nursing Facility or Other Community Settings

- Co-design handover communication processes (i.e. preferred formats for information)
- Create processes for bidirectional communication for care coordination, continual learning and ongoing improvement efforts

Handovers to Home Health Care, Skilled Nursing Facilities or Community Services

- Share patient education materials and educational processes across care settings
- Offer education for the staff in HHC, SNF, LTC and community services

INTERACT Transfer Tool



RESIDENT TRANSFER FORM

INTERACT II

SENT TO: *(Name of Hospital)*

SENT FROM: *(Name of Nursing Home)*

Date:___/___/_____ Unit: _____

RESIDENT: *Last Name* *First Name* *MI*

DOB:____/____/_____
Language: English Other:_____
Resident is: SNF/rehab Long-term

CONTACT PERSON:
(Relative, guardian or DPOA/Relationship)
name
Is this the health care proxy? Yes No
Telephone:( )_____-_____
Notified of transfer: Yes No
Aware of diagnosis: Yes No

CODE STATUS:
DNR DNH DNI Full Code

MD/NP/PA IN NURSING HOME:
MD NP PA
name
Telephone:( )___-____ Pager:( )___-____

WHO TO CALL TO GET QUESTIONS ANSWERED ABOUT THE RESIDENT?
name *title* Telephone:( )___-____

REASON FOR TRANSFER *(i.e., What Happened?)*

List of Diagnoses:_____

VS: BP____ HR____ RR____ T____ pOx____ FS glucose ____ Time Taken: ____:____ AM/PM
Allergies:_____ Tetanus Booster *(date)*:____/____/_____

Usual Mental Status:
- Alert, oriented, follows instructions
- Alert, disoriented, but can follow simple instructions
- Alert, disoriented, but cannot follow simple instructions
- Not alert

Usual Functional Status:
- Ambulates independently
- Ambulates with assistance
- Ambulates with assistive device
- Not ambulatory

Please see SBAR form for additional information

DEVICES / SPECIAL TREATMENTS:
IV/PICC line
Pacemaker
Foley Catheter
Internal Defibrillator
TPN
Other:_____

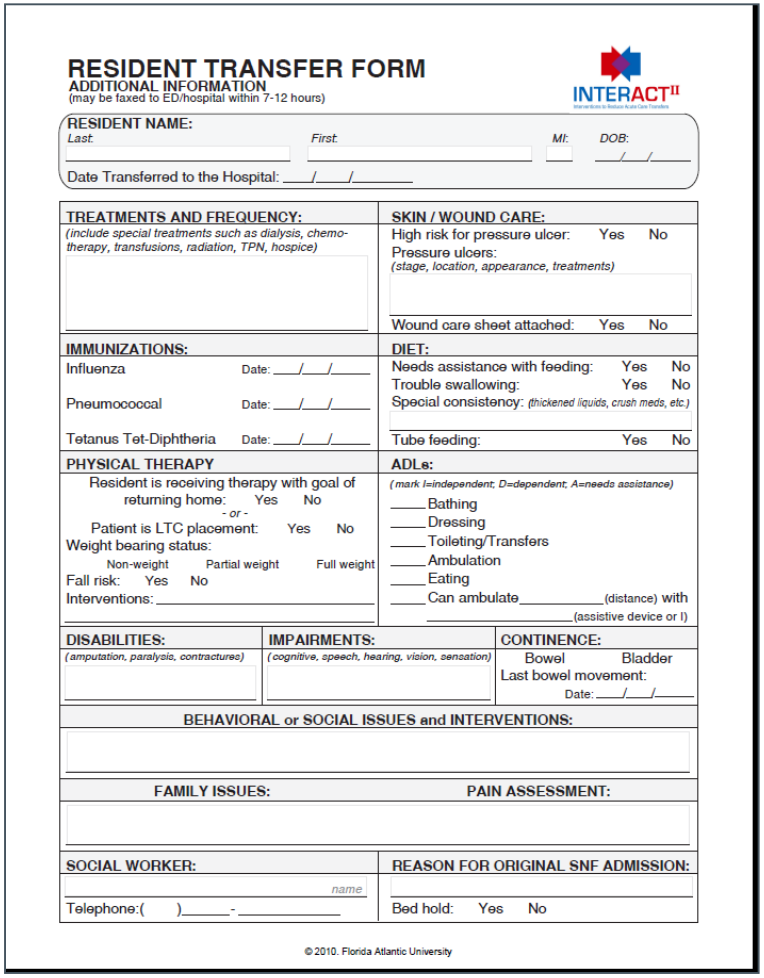
AT RISK ALERTS:
None Seizure
Falls Harm to:
Pressure Self Others
Ulcer Restraints
Aspiration Limited/non-weight
Wanderer bearing: Left Right
Elopement Other:_____

ISOLATION / PRECAUTION:
MRSA VRE
C-Diff
Other:_____
Site:_____
Comment:_____

CAPABILITIES OF THE NURSING HOME TO CARE FOR THIS RESIDENT:
IVF therapy IV antibiotics MD/NP/PA follow up visit within 24 hours
Q shift monitoring by an RN Other:_____

NURSING HOME WOULD BE ABLE TO ACCEPT RESIDENT BACK UNDER THE FOLLOWING CONDITIONS:
ED determines diagnosis, and treatment can be done in NH
VS stabilized and follow up plan can be done in NH
Other:_____

Form Completed By:
name *title* *signature*
Report Called In By: Report Called To:
name *title* *name* *title*



RESIDENT TRANSFER FORM
ADDITIONAL INFORMATION
(may be faxed to ED/hospital within 7-12 hours)

INTERACT II

RESIDENT NAME:
Last: *First:* *MI:* *DOB:* ___/___/_____
Date Transferred to the Hospital: ____/____/_____

TREATMENTS AND FREQUENCY:
(include special treatments such as dialysis, chemo-therapy, transfusions, radiation, TPN, hospice)

SKIN / WOUND CARE:
High risk for pressure ulcer: Yes No
Pressure ulcers:
(stage, location, appearance, treatments)
Wound care sheet attached: Yes No

IMMUNIZATIONS:
Influenza Date: ___/___/_____
Pneumococcal Date: ___/___/_____
Tetanus Tet-Diphtheria Date: ___/___/_____

DIET:
Needs assistance with feeding: Yes No
Trouble swallowing: Yes No
Special consistency: *(thickened liquids, crush meds, etc.)*
Tube feeding: Yes No

PHYSICAL THERAPY
Resident is receiving therapy with goal of returning home: Yes No
- or -
Patient is LTC placement: Yes No
Weight bearing status:
Non-weight Partial weight Full weight
Fall risk: Yes No
Interventions:_____

ADLs:
(mark I=independent; D=dependent; A=needs assistance)
____Bathing
____Dressing
____Toileting/Transfers
____Ambulation
____Eating
____Can ambulate_____(distance) with _____(assistive device or I)

DISABILITIES:
(amputation, paralysis, contractures)

IMPAIRMENTS:
(cognitive, speech, hearing, vision, sensation)

CONTINENCE:
Bowel Bladder
Last bowel movement:
Date: ___/___/_____

BEHAVIORAL or SOCIAL ISSUES and INTERVENTIONS:

FAMILY ISSUES: **PAIN ASSESSMENT:**

SOCIAL WORKER:
name
Telephone:( )_____-_____

REASON FOR ORIGINAL SNF ADMISSION:
Bed hold: Yes No

Available at: http://interact2.net/tools_v3.aspxnteract2.net

Post-hospital Follow-Up Phone Calls

- Have been frequently cited as a cost-effective method to enhance communication with patient/caregiver in the critical period following discharge
- Give patient/caregiver the opportunity to reinforce education and assess self-care knowledge through the use of Teach Back
- There is little standardization or consensus on the timing and frequency of post-discharge follow-up calls

Johnson M, Laderman M, Coleman E. *STAAR Issue Brief: Enhancing the Effectiveness of Follow-up Phone Calls to Improve Transitions in Care*. Cambridge, MA: Institute for Healthcare Improvement; 2012.

How much coordination do you have?

- How many services are wrapped around the patient or family caregiver?
  - Are all of the services communicating? Do they all understand the Plan of Care?
  - If multiple services are involved, is a “lead person” identified and communicated to the patient/caregiver and the care team?
- How many phone calls is the patient/caregiver receiving after they get home?
- What is the purposes of each call?

Using Process Measures to Guide Your Learning

Number of discharges in the sample where critical information is transmitted at the time of discharge to the next care site or person continuing care (e.g., home health care, long-term care facility, rehab care, physician office, or care at home)

Definition details on page 71 of the How-to Guide

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Using Process Measures to Guide Your Learning

Percent of patients discharged who had a follow-up visit scheduled before being discharged in accordance with their level of assessed risk

Definition details on page 72 of the How-to Guide

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What Are We Learning About Providing Handover Communications?

- There are a “vital few” critical elements of patient information that should be available at the time of discharge for the community providers
  - “Senders” and “receivers” agree upon the information and design reliable processes to transfer information effectively
- Written handover communication for the patient at risk is insufficient; direct verbal communication allows for inquiry and clarification

What Are We Learning About Providing Handover Communications?

- Ensure that the an appropriate and timely discharge summary is available for office visits prior to the patients appointment
- Written care plans for patients and family caregivers should use clear, user-friendly formats for describing care at home

Table Exercise

- **In your work what area of focus needs attention?**
- **Pick a focus and discuss what your next test or steps will be.**
  - **Medication Reconciliation**
  - **Timely follow up appointments at time of discharge**
  - **Follow up phone calls**
  - **Comprehensive discharge plan**
  - **Communication with community provides**
  - **Tracking of readmissions to identify trends**