This activity is part of the North Carolina Virginia Hospital Engagement Network (NoCVA)
NoCVA is led by the NC Quality Center in partnership with the VA Hospital and Healthcare Association
NoCVA exists to support the goals of the CMS national effort - *The Partnership for Patients*
Partnership for Patients Goals

• By the end of 2013, preventable hospital acquired conditions would be reduced by 40%, compared to 2010.
• By the end of 2013, 30-day hospital readmissions would be reduced by 20%, compared to 2010.
• This Collaborative is designed to impact the goal of reducing avoidable readmissions.
Objectives

- Describe tools and strategies for improving the assessment of post-hospital needs
- Understand methods for enhancing patient learning
- Share strategies and methods currently in use
- Review next steps of collaborative activity
Methods

• Identify the pilot unit
• Recruit and prepare a project team
• Complete an assessment of five recent readmissions
• Conduct observations of patient admission, patient education, and patient discharge
• Develop value stream process maps of the discharge process
• Develop value stream process maps of medication reconciliation at discharge
We have completed the diagnostic assessment of readmissions for

- One patient
- Two patients
- Three patients
- Four to Five patients
- None yet
1. We have completed a gemba walk of the discharge process, and completed a value stream map of our discharge process
2. We have done a gemba walk, and started our VSM
3. We haven’t started yet, but we will!
1. We’ve submitted our definition of “critical info”
2. Not yet, we’re working on it
Methods

• Review assessment and observation information and process maps

• *Develop targets for improvement in 4 areas:*
  o Enhanced assessment of patient post-hospital needs
  o Effective teaching and enhanced patient learning
  o Ensuring post-hospital care follow-up
  o Providing real-time handover communications

Develop action plans for improvement activities related to the four improvement targets
Methods

- Participate in community engagement readiness assessment
- Identify and connect with community organizations, services and practices
- Participate in monthly educational webinars and quarterly group coaching calls
- Participate in in-person learning sessions
Excluding patient and family
Accepting unrealistic optimism
Lack of understanding functional status
Not addressing whole patient
Not addressing end of life issues
Med errors, polypharmacy, poor med rec
Labeling patient as noncompliant
Missing worsening clinical status in hospital
What are your typical problems?

• Raise your hand to have your line unmuted to speak

    OR

• Type your responses into the chat box
Recommended changes:

- Involve the patient, family caregivers, and community providers as full partners in completing a needs assessment of the patients home-going needs
- Reconcile medications upon admission
- Identify the patients initial risk of readmission
- Create a customized discharge plan based on the assessment
Recommended changes:
Involve the patient, family caregivers, and community providers as full partners in completing a needs assessment of the patient's home-going needs.

- Who lives with you?
- Who takes care of your medication?
- Who makes your doctor’s appointments?
- Who prepares your meals; who cooks?
- Who does the housework?
- Who does the grocery shopping?
- Who else do you want involved in your care?
- When is the best time for them to be here to learn with you?
- Who do you want present or involved with your discharge instructions and self-management support?
For patients readmitted within 30 days, ask:

- How do you think you became sick enough to come back into the hospital?
- Did you see your doctor or another clinician in the office before you came back into the hospital?
- Describe any difficulties you had getting an appointment or attending the office visit.
- Has anything gotten in the way of you taking your medicines?
- How do you take your medicines and set up your pills every day?
- Describe your typical meals since you returned home from the hospital.
Proactive end-of-life counseling and palliative care referrals
Involve patient and family in needs assessment: Tools

- Transitions of Care Checklist (National Transitions of Care Coalition)
- Your Discharge Planning Checklist (CMS)
- The Care Transitions Intervention podcasts
- http://www.rarereadmissions.org/documents/Webinar_Care_Trans_Interv_p1_20110608.mp3
• Recommended changes:
  o Involve the patient, family caregivers, and community providers as full partners in completing a needs assessment of the patient's home-going needs
  o **Reconcile medications upon admission**
  o Identify the patients initial risk of readmission
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Reconcile Medications at Admission

- Involve the patient and family, primary care physician and pharmacist
- Include home care services
- Include in medical record
Reconciling Medications at Admission: Tools

- Improving Care Transitions: Optimizing Medication Reconciliation (American Pharmacists Association and American Society of Health System Pharmacists)
  http://www.rarereadmissions.org/documents/Medication_Reconciliation_2012_03.pdf

- Medication Discrepancy Tool (Eric Coleman, University of Colorado)

- Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation (Northwestern Memorial Hospital, Northwestern University and The Joint Commission)
  http://www.ahrq.gov/qual/match/
Assessing Post-Hospital Needs

- **Recommended changes:**
  - Involve the patient, family caregivers, and community providers as full partners in completing a needs assessment of the patient's home-going needs
  - Reconcile medications upon admission
  - **Identify the patient's initial risk of readmission**
  - Create a customized discharge plan based on the assessment


Institute for Healthcare Improvement, 2011
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. Asking the patient directly 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. The data elements or variables in risk tools available are largely similar. Some require more advanced data capabilities than others. There are inconsistencies regarding which characteristics are most predictive. One possible explanation is that nonpatient factors may have a larger role in readmission rates, such as the health care system and access.
Identify the patient’s initial risk of readmission: Tools

Assessing Post-Hospital Needs

• Recommended changes:
  o Involve the patient, family caregivers, and community providers as full partners in completing a needs assessment of the patients home-going needs
  o Reconcile medications upon admission
  o Identify the patients initial risk of readmission
  o Create a customized discharge plan based on the assessment
Customized Discharge Plan

- Assess and predict discharge basic needs
- Communicate with agencies early
- Discuss discharge preparation in daily multidisciplinary rounds
- Re-evaluate the estimated discharge date and adjust the plan
- Standardize the discussion of home-going preparations
- Include progress toward going home in daily goals
Ask regularly, in rounding:

- Where will the patient likely go after discharge?
- Who will be providing the care?
- Does the patient require a higher intensity of care?
- What are the patient’s needs after discharge?
- What are the potential discharge barriers?
Create a customized discharge plan based on the assessment:

**Tools**

- Discharge Knowledge Assessment Tool
  [http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&Template=/CM/ContentDisplay.cfm&ContentID=12942](http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&Template=/CM/ContentDisplay.cfm&ContentID=12942)

- Patient Activation Assessment Form
  [http://www.caretransitions.org/documents/Activation_Assessment.pdf](http://www.caretransitions.org/documents/Activation_Assessment.pdf)
Provide Effective Teaching and Facilitate Enhanced Learning: Typical Failures

• Assuming that the patient is the key learner
• Providing 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
• Inability of patients to ask clarifying questions
• Non-adherence of patients regarding self-care, diet, medications, therapies, daily weights, follow-up and testing due to patient and family confusion
What are your local typical problems with patient education?

- Raise your hand and we will unmute your line so you can speak
- OR
- Type your comments into the chat box
Effective Teaching and Enhanced Patient Learning

• Recommended Changes:
  o **Involve all learners in patient education**
  o Redesign the patient education process
  o Redesign patient teaching print materials
  o Use Teach Back regularly throughout the hospital stay to assess the patient’s and family caregivers’ understanding of discharge instructions and ability to perform self-care
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Citation: Institute for Healthcare Improvement, 2011
• Use Ask Me Three™ National Patient Safety Foundation. Ask Me 3TM.  
http://www.npsf.org/askme3
• During acute care hospitalization, only essential education: need-to-know
• Emphasize what the patient should do--action
HOW to teach

- Slow down
- Plain language
- Use Teach Back
- Highlight or circle key info in print material
- Avoid duplication of paperwork
- Provide office practices and SNFs a copy of patient education packet
- Agenda-Setting Communication Cards
Redesign Patient Education: Tools

- CHF Agenda-Setting Cards (Cedars Sinai Medical Center. 
- Plain Language Association International 
  [www.plainlanguagenetwork.org](http://www.plainlanguagenetwork.org)
- Clear Language Group 
  [www.clearlanguagegroup.com](http://www.clearlanguagegroup.com)
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Citation: Institute for Healthcare Improvement, 2011
Reader-Friendly Print Materials

- Simple words (one or two syllables)
- Font size 14 point
- Short sentences (four to six words)
- Short paragraphs (two to three sentences)
- No medical jargon
- Consistent language
- Two word explanations (e.g. water pill or blood pressure pill)
- Remove ranges
- Use much white space, pictures, and visual aids
- Need-to-know only
- Verbal words and written material match
Redesign Print Materials: Tools

Effective Teaching and Enhanced Patient Learning

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  o **Use Teach Back regularly throughout the hospital stay** to assess the patient’s and family caregivers’ understanding of discharge instructions and ability to perform self-care

Citation: Institute for Healthcare Improvement, 2011
Teach Back Tips

- Explain needed info to all key learners
- Stop and check for understanding: ask respectfully
- Check for understanding after each segment of information
- If a gap in understanding is found, offer additional teaching
- Use multiple opportunities to review
- If the patient or caregiver cannot teach back, inform the care providers in the next setting of care and adjust the transition plan accordingly
Video example of Teach Back

http://nchealthliteracy.org/teachingaids.html
Teach Back: tools

- Health Literacy Manual. American Medical Association (email healthliteracy@ama-assn.org)
Questions?
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<tr>
<th>August 9</th>
<th>9:00 – 10:00</th>
<th>Understanding the Community Engagement Process; Cross Continuum Teams</th>
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<tbody>
<tr>
<td>Future dates</td>
<td>Topics: Testing and Implementing Improvements; others as needed</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Task</td>
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<tr>
<td>Aug 1</td>
<td>Submit value stream process map of discharge to Quality Center</td>
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<tr>
<td>Aug 6</td>
<td>Submit definition of ‘critical information’ (hospital-defined)</td>
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<tr>
<td>Aug. 20</td>
<td>Submit med rec and handover communication data to QDS</td>
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<tr>
<td>Sept. 4</td>
<td>Complete all 5 diagnostic tool assessments of readmissions</td>
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<tr>
<td>Sept. 4</td>
<td>Complete value stream map of med rec</td>
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<tr>
<td>Oct. 1</td>
<td>Review all assessment data, set aims for first two improvement areas: Perform an Enhanced Assessment of Post-Hospital Needs and Provide Effective Teaching and Facilitate Enhanced Learning</td>
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<tr>
<td>Oct. 22</td>
<td>Team completes Team Assessment Tool and submit to QDS</td>
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<tr>
<td>Nov. 1</td>
<td>Test an improvement in the first two areas</td>
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Contacts

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