ICAHN
Illinois Critical Access Hospital Network

Improving Care Transition Scores

STRATEGIES TO IMPROVE CARE TRANSITION HCAHPS SCORES

Objectives for today:

- Discuss the HCAHPS questions in the Care Transitions Measure composite
- Define and Discuss Transition of Care
- Evaluate action strategies to improve Care Transitions

Care Transition Composite

Understanding your care when you left the hospital

- Questions 20, 21, 22
  - During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I left the hospital.
  - When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
  - When I left the hospital, I clearly understood the purpose for taking each of my medications.

For these three questions, results will be calculated using the Likert scale. Remember:

In HCAHPS, the Likert scale allows patients to report the degree of their agreement with

The statement, using *strongly agree, agree, disagree, and strongly disagree or don't Know/don't remember/not applicable*. Results are then reported on a 0-100 basis using those responses.

Source: The HCAHPS Handbook

Let’s examine each question:

The Hospital staff took my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I left.

- Involve the patient and family in the Plan of Care on Admission, and yes that includes the transition of care
- Identify the family member or members who will be assisting the patient post-discharge
- Make sure social work/discharge planner are involved early to assist with identification of resource needs

- Continued…….
- Bedside shift report
- Nurse leader Rounding
- Talk with the patients about the help they will have upon their discharge, and talk about it on admission and frequently throughout the hospital stay.
- Write down their needs and preferences on the communication (white) board.

Next question……

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

- Interdisciplinary rounds with a focus on the care transition plan. Involve the case management staff, pharmacy staff, dietician, and the care providers.

- Use key words at key times to help the patients understand their responsibilities such as bathing, dressing, toileting to name a few basic needs. Discuss who is responsible to assist if needed and also address if outside resources will be needed.

- Arrange appointments and referrals while the patient is in the hospital and discuss this with them frequently including how they will get to their appointments.

Continued……

- Ask the patient and their caregivers to repeat back the information you have shared and gain consensus

- Provide post discharge follow up phone calls. This is an opportunity to check in on patients and make certain they are okay and to review their discharge plan, reinforcing their responsibilities.

- This time also gives us the opportunity to make certain they are aware of follow up appointments and have transportation, have gotten their prescriptions filled, and to make certain that any agencies such as Home Health/DME has made contact.

- Make certain the planned discharge date is on the white board.

Next question……

When I left the hospital, I clearly understood the purpose for taking each of my medications.

- Communication is key. Use key words at key times to ensure meaningful communication about medications. Invite questions try using “ what questions do you have for me” rather than do you understand.

- Make sure they have a well written medication list that includes the medication, what it is for, potential side effects, and when they are to take it. In addition, have them repeat back to you what the medication is for and when to call the doctor for potential side effects.

Overall Recommendations: NTOCC

To achieve successful transitions of care, the National Transitions of Care Coalition recommend that we:

- Improve communication
- Implement electronic health records that include standardized medication elements
- Expand the role of pharmacists
- Establish points of accountability
- Increase use of case management and professional care coordination
- Implement payment systems that align incentives
- Develop performance measures to encourage better transitions of care

After his family dog Dutch, was hit by a car, Jay LaBine, MD, Associate CMO of Spectrum Health, took him to the local animal hospital. Before the dog was released, the veterinarian sat down with Dr. LaBine for forty-five minutes giving an in-depth instructions on how to care for Dutch at home. Dr. LaBine discovered the unsettling reality that a veterinarian took more time with a pet owner to explain the care expectations for a recovering dog than a physician might spend with a human patient preparing for discharge.

Source: Beckers Hospital Review

HCAHPS survey

- Communication is key in all domains of the HCAHPS Survey. Enhanced communication between our Patients and Care Givers is key to improving the quality and safety of patient care. It is key that we:

- Treat patients with courtesy and respect

- Listen carefully to our patients

- Explain things in a way the patient can understand.

Transitional Care-What exactly is it?

- Complete and through discharge plan
- Post-discharge telephonic outreach
- Patient centered discharge instructions
- Medication Reconciliation
- Follow-up with primary caregiver

Summary

- Clear and understandable communication. Must be two-way

- Avoid healthcare terminology it can be very confusing. Use explanations that are easily understood.

- Assess discharge readiness:
  - Post discharge support needed
  - Transportation
  - Pharmacy
  - Basic tools needed at home
  - Financial considerations

Day of Discharge Process

- If we have done our job well throughout our patients stay, all of this information should simply be a review of what they already know!

- This ultimately leads to better outcomes and well informed patients that will be able to answer ***Strongly Agree*** when they complete their survey.

Conversation example:

- Nurse: “Good Morning Mrs. Jones. This is your discharge planning checklist. This checklist will help you, your family and the care team plan for your discharge. Please share any concerns you may have about your plan at and we will review this together at a good time for you.”

- Mrs. Jones: “Good, I do have some concerns about my follow-up care.”

Continued…….

- Dietician: “Hi Mr. Brown, we have several educational materials we want to share with you and your family regarding your food choices and diabetes. Should we wait for a member of your family to return?”

- Mr. Brown: “Yes, my son does all of the cooking and will need to know what I should eat.”

Parting thought…….

- If you received a copy of your discharge instructions is it:
- Clear
- Concise
- Medication Reconciliation easy to understand
- Next appointment scheduled with primary care
- Have all the instructions been discussed with you prior to discharge

Thank you