Part 3: HCAHPS Webinar - Communication about Medications, Discharge Information & Care Transitions

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Missouri Hospital Association

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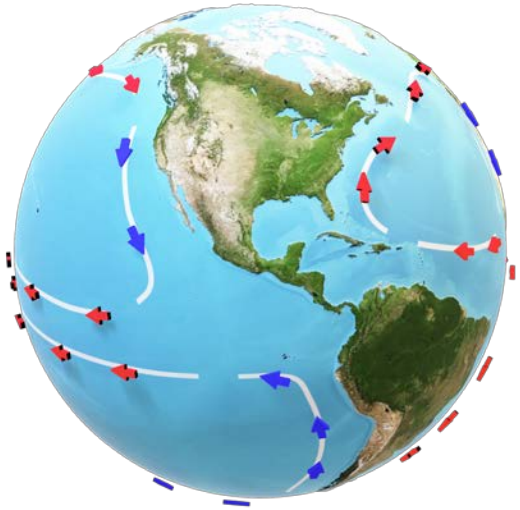
Where We're Headed



- April - Medication Communication, Discharge Information, & Care Transitions

Where we've been:

- February – HCAHPS Overview
- March - Focus on Communication: Nurse Communication, Physician Communication, & Responsiveness of Hospital Staff

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Patient Voices – Start with a Story

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Focus on: Communication about Medications, Discharge Information & Care Transitions

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Top Box % Change from 2008 to 2018

	2008	2018	% Change
Overall Hospital Rating	64%	73%	9%
Responsiveness	62%	70%	8%
Disch Info	80%	87%	7%
Med Comm	59%	66%	7%
Nurse Comm	74%	81%	7%
Quietness	56%	62%	6%
Cleanliness	69%	75%	6%
Willingness to Recomm	68%	72%	4%
Care Transitions (started in 2014)	51%	53%	2%
Doctor Comm	80%	81%	1%

Resource: Summary of HCAHPS Survey Results Table (through December 2018) www.hcahpsonline.org

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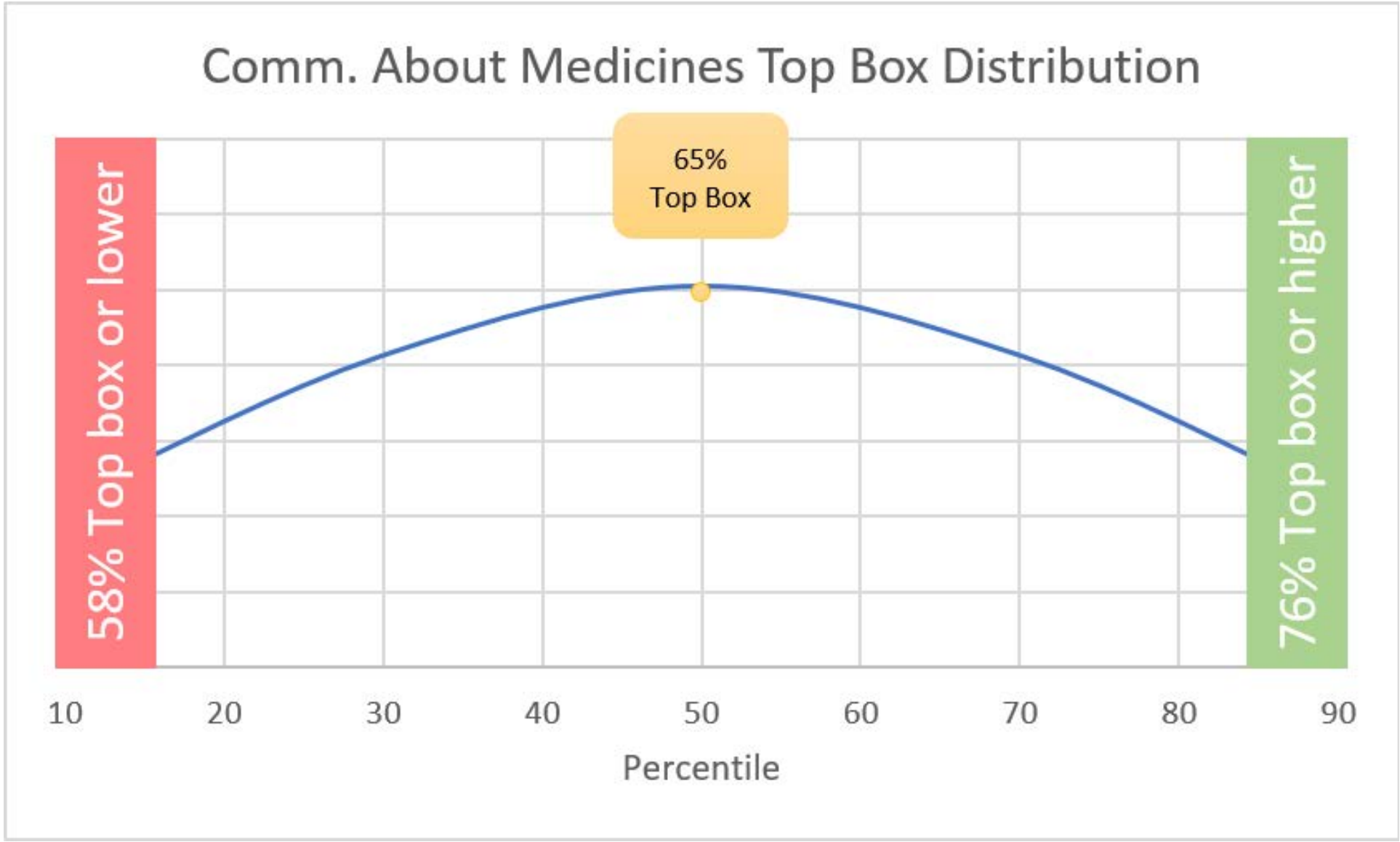
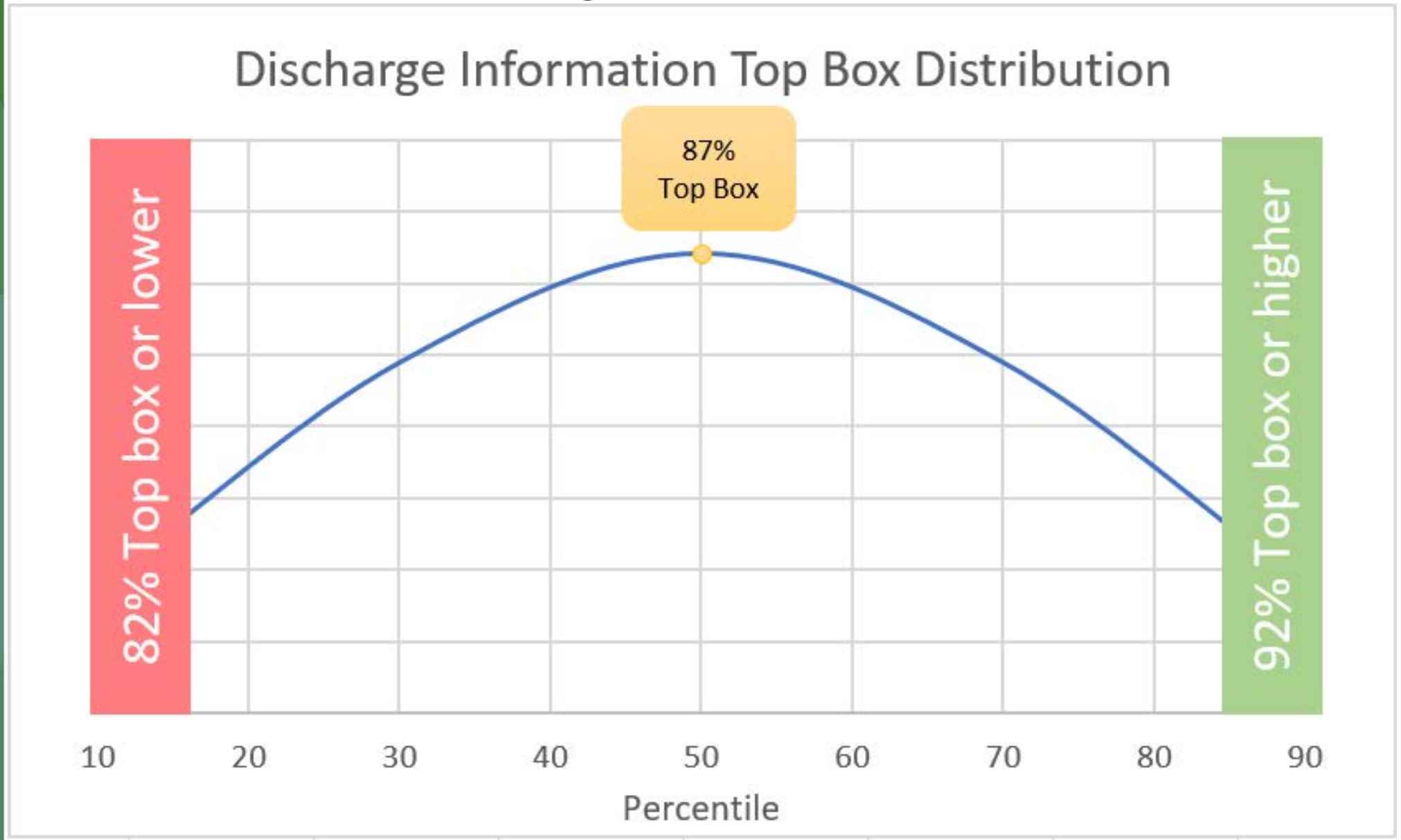
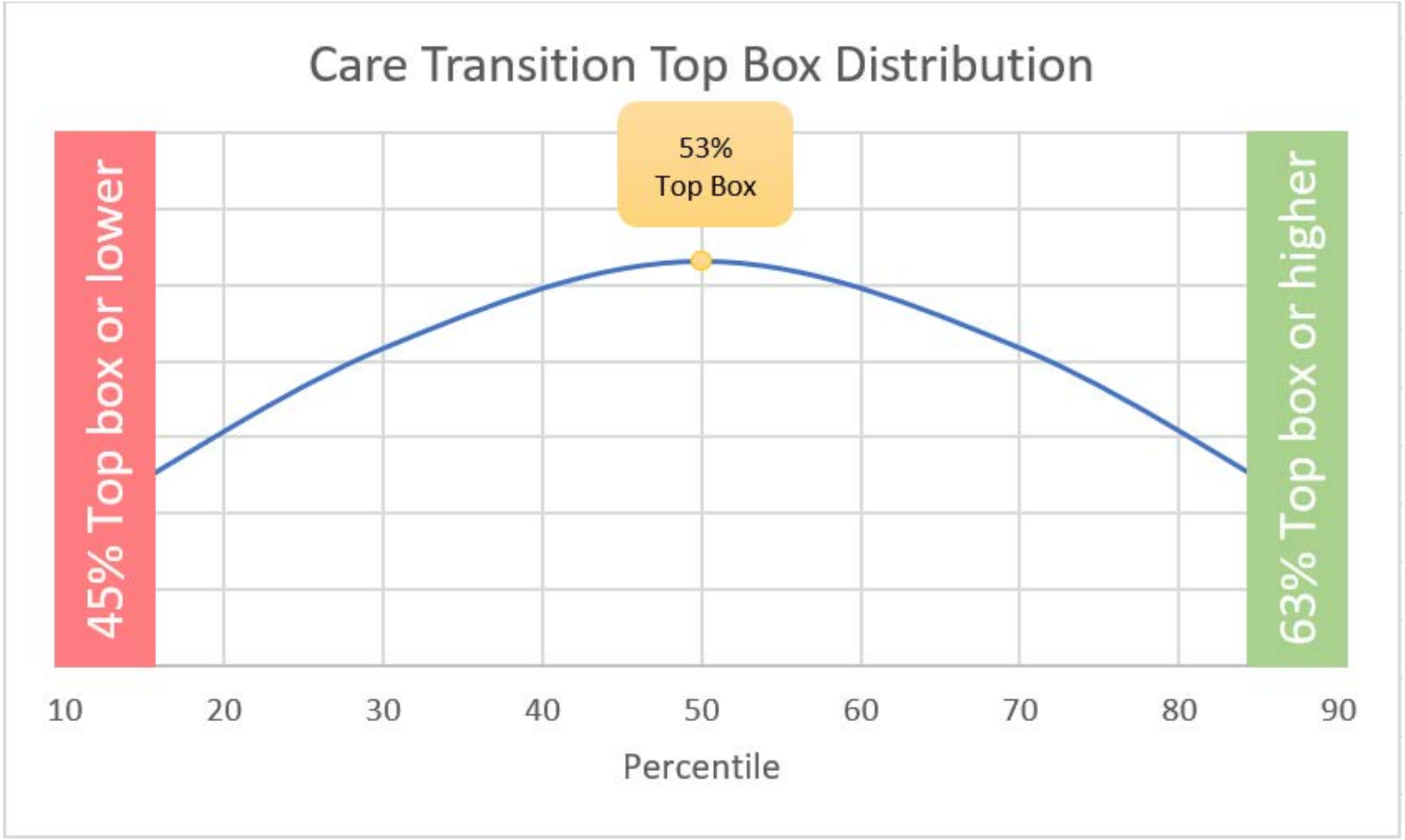
Medication Communication



Discharge Information



Care Transitions



Transitions, Handoffs, Information & Education

Medication Communication The Challenge

In a study

- 66% of patients surveyed did not know the duration of treatment of their medications
- Only 35% of patients knew the side effects of their medications

Reference: Hays, Ron D., et al. "Physician Communication When Prescribing New Medications." Archives of Internal Medicine 166, no. 16 (2006): 1855-62.

In another study

- 28% of patient knew their medication names
- 37% of patients knew the purpose of those medications
- 14% of patients knew the side effects of their medications

Resource: State University of New Your Study, Mayo Clinic Proceedings, August 2005.

Medication Communication The Challenge

Patient Perspective

- 25% of patients said their physician never told them about a new medication, and only 10% said their physician discussed the side effects

Physician Perspective

- 100% of physicians said they told their patients about new medicines, and 81% said they explained the side effects to patients

Resource: Archives of Internal Medicine, November, 2010

Medication Communication
The Challenge

Information presented verbally is remembered correctly only 14% of the time,

but is remembered correctly 80% of the time when presented verbally with a visual aid (handout).

Resource: Houts PS, Bachrach R. Witmer JT, et al. Using pictographs to enhance recall of spoken medical instructions. Patient Educ Couns 1998;35: 83-8.

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Medication Communication
Why is it so important?

Adverse drug effects = major source of Hospital Acquired Conditions

Medicare Readmissions Penalty

- Year One: 67% of Hospitals had a penalty
- Average hospital penalty: $125,000
- 25% of readmissions attributed to patient non-adherence

Medicare Value-based Purchasing (VBP) Incentive Payments

- ~1/3 of substantive HCAHPS questions now ask about medications and care transitions

Medication Communication Requirements

Explain each medication at each dose

- Hardwire the explanation of every medication with every dose given
- Encourage patient engagement: "Before I give you this, do you know what it's for and what side effects it may have?"
- Consider 6 critical components:

- ❑ Name
- ❑ Purpose
- ❑ Duration
- ❑ When will it take effect
- ❑ Dosage
- ❑ Side effects

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Medication Communication Improvement Approach

Give this information in doses

 pun intended!

- Think of it as a multi-layered approach
- Provide continual reinforcement

Consider these key touch points

- When the patient is first admitted
- During bedside shift report
- As part of discharge education
- During the follow up post-discharge phone call

Give this in manageable bites

- Make sure the most important parts are absorbed, not obscured by too many details
- Use plain, understandable language
- Focus on the big 3:
  - ❑ Name of medication
  - ❑ Side effects
  - ❑ Purpose (what is it for)

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Medication Communication Improvement Techniques – Ask 3/Teach 3

Use the teach-back method to evaluate understanding and clarify miscommunications

Make handouts available on the intranet to assist with patient medication education

Ask 3: Patient

Information can be included in a welcome guide that encourages patients to "Ask 3" questions about each prescribed medication.

1. What is the name(s) of the medication?
2. Why do I need to take it?
3. What are possible side effects?

Teach 3: Caregiver

Teach 3 with each medication

1. Name of the medication
2. Purpose of the medication
3. Side effects (using the phrase "side effects" in the conversation)

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Medication Communication Improvement Techniques – M in the Box SM

Box drawn on the care board

When a new med is ordered, nurse educations the patient and puts a "M" in the box

- "Ms. Gray, I'm writing the M in the box to remind us both that you have a new medication. We have talked about the reason for this medication and some of the possible side effects."

During bedside shift report, outgoing nurse points it out to incoming nurse

- Dr. Smith ordered Ms. Gray a new medication.
- Ms. Gray do you remember the name?
- Can you please tell me why Dr. Smith ordered it for you?
- Can you please tell me about one of the side effects?

Once the patient can tell the incoming nurse about this, they erase the "M" and leave the box open if a new medication is ordered during that shift.

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Reference: Studer Group

Medication Communication Improvement Techniques – Patient Education

Engage frontline staff to determine most common medications given to patients

- Develop patient handouts
  - Include spots for the purpose and the side effects
  - Vet the language, font, layout of the handout with patients and families
- When a new medication is given, utilize the handouts
  - Have the nurse take a highlighter and highlight the side effects on the patient handout
  - Some facilities leave these forms also in the med room to prompt nurses when they are prepping meds to bring a handout too
- Provide a Patient Medication Folder to put all of their medication handouts in
- Make sure discharge instructions prompt staff to also review the distribution of medication handouts

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Medication Communication Improvement Techniques

Encourage two-way communication

- Sit
- Listen
- Repeat key points
- Use key words to ensure two-way dialogue about medications
  - Use patient friendly terms – simpler words, shorter sentences
  - Pause to allow questions
  - Use whiteboard and other tools for intra-team communication about education
- Use open-ended questions
  - "What questions do you have about your medications?"
- Ask about patient's compliance
  - "What might prevent you from taking this medication when you go home?"
  - "Why is it important to continue taking it?"

Medication Communication Improvement Techniques

Reinforce medication education into bedside shift report

- Review the printed list of medications with patient and nurse
- Literally highlight medication instructions & side effects
- Engage the patient in the conversation
- Re-explain the medication
- Refer to the M in the Box SM

Incorporate into leadership rounding

- What questions or concerns do you have about your medications?
- Tell me about any new medications you may be taking?
- How have you been feeling on them?
- What side effects are you watching for with those?
- Reference the Patient Medication Folder and side effects
- Reference the white board - M in the Box SM

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Medication Communication Improvement Techniques

Make post-visit calls and include medication information

- Check on the medications
  - Were new prescriptions filled?
- Link back
  - "Remember when the nurses at the hospital would change shifts and review your medicines and side effects?"
- Use key words that align with the explanation of medication
  - "What side effects are you watching for?"
- Have the primary nurses call if possible

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Why is Discharge Information Important?

- AHRQ Study:
  - Patients being discharged from the hospital who have a clear understanding of their after-hospital care instructions
    - Including how to take their medicines and when to make follow-up appointments,
    - Are 30 percent *less* likely to be readmitted or visit the emergency department than patients who lack this information

- Health Research and Educational Trust of the American Hospital Association research suggests that the following can all add to preventable readmissions:
  - Poor transfer of information to patients (on such issues as medication or warning signs)
  - Lack of timely post- discharge physician visit
  - Poor patient knowledge
  - Non-disclosure of current drug therapy

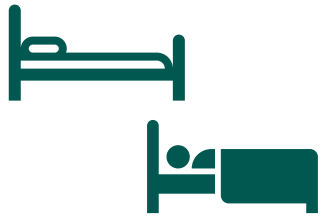
Source: The Beryl Institute

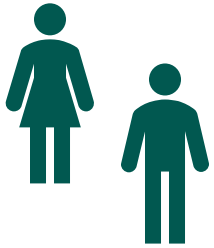
What is a Transition of Care?

Movement of an individual

- Between locations
  - Hospital to SNF
  - Hospital to home with home health

- Between levels of care
  - ICU to Med Surg
  - Rehab to LTC in SNF





- Between providers
  - One physician to another
  - Hospital to PCP
- Across healthcare states
  - Curative to Palliative to Hospice care

Resource: Relias Learning Webinar on Care Transitions: implementing Proper Transitions of Care to Prevent Rehospitalization. Retrieved from https://www.relias.com/resource/implementing-proper-transitions-of-care

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Care Transitions: Why are they so important?

1. Adverse events
   - About 1 in 5 patients suffer an adverse event during the care transition period, medication-related events being the most common
   - 20% of patients suffers an adverse event within 3 weeks of hospital discharge
2. Unnecessary readmissions
   - About 1 in 5 patients are re-hospitalized within 30 days of discharge, and of these readmissions, 75% are potentially avoidable
   - 20% of Medicare patients are readmitted within 30 days of hospital discharge
   - 2.3 million ED visits per year are from patients discharged from the hospital within the previous 7 days
3. Unnecessary pain and suffering often occurs when patients are not properly educated about how to successfully manage pain at home
4. Poor HCAHPS Scores and financial penalties
   - Patients who suffer from poorly-managed discharges and care transitions reflect their dissatisfaction on their HCAHPS survey
   - Low scores and preventable readmissions lead to financial penalties for the hospital

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Resource: HCAHPS Breakthrough Webinar Series – Care Transitions Done Right and Care Transitions: A Bridge over Troubled Water By: Rebecca Smallwood, RN, MBA March 3, 2017;

Care Transitions: Contributing Factors to Failures

- Insufficient **follow-up**
- **Medication**-related issues
- Failed **handoffs**
- **Patient communication issues**
- Hospital-acquired **infections**
- Poor **discharge planning**
- High-risk **clinical** and **demographic** factors

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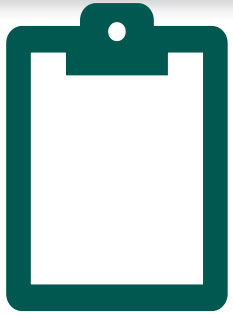
Care Transitions: Perspectives

Care Transitions: Supportive Strategies



Rounding

Care boards

Teach back

Post-discharge phone calls

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Duh - this is everything I normally do

Spectrum of Strategies

Strategy	Communication about Medications	Care Transitions
Leader Rounding on Patients 	What questions or concerns do you have about your medications? Tell me about any new medications you may be taking? How have you been feeling on them? What side effects are you watching for with those?	Ensure patients know and understand their medications and other discharge care instructions Incorporate tools such as teach back or checklists Designated time to make follow up appointments Review red flags for the patients
Care Boards 	Utilizes M in the Box℠ for new medications	Anticipated date of discharge Discharge checklist (attached to or incorporated onto the board)
Teach Back 	Ask3/Teach 3 Used about medications & side effects	Used to have patients help explain how they will manage care on their own in next setting/care transition. “Can you tell me what the two medications are for, when you’ll take them…”
Post-Discharge Phone Calls 	Check on the medications: Were new prescriptions filled? Link back: “Remember when the nurses at the hospital would change shifts and review your medicines and side effects?" Use key words that align with the explanation of medication: “What side effects are you watching for?"	Review key information about care transitions: Follow up appointment Post discharge services What do to do if a problem arises

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Effective Care Transitions

- ✓ Care coordination
- ✓ Patient and family education
- ✓ Accountable provider at all points of care transition
- ✓ Begins at the time of admission

Care Transition: Key Components

- ✓ Discharge planning
- ✓ Complete communication of information
- ✓ Availability, timeliness, clarity, and organization of information transfer
- ✓ Medication safety & reconciliation
- ✓ Patient education and promotion of self-management
- ✓ **Enlisting the help of social and community supports**
- ✓ Advance care planning
- ✓ Attention to coordinating care among team members
- ✓ Monitoring and managing symptoms after discharge
- ✓ Outpatient follow-up

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Resource: Care Transitions: A Bridge over Troubled Water By: Rebecca Smallwood, RN, MBA March 3, 2017

Care Transition Improvement Techniques: Patient & Family Education

Goal of patient and family education and engagement: preparing for what comes next (especially if it's home!)

- Preparation for transfer
- Education for self-care management
- Agreement with the care transition
- How are they going to manage their condition?
- Ability to recognize warning signs?
- Ability to act on those warning signs?

Consider

- Are they ready to learn?
- What are their strengths/limitations? (consider language, literacy, health literacy)
- What do they need to know (vs. nice to know)
- How does this person *prefer* to learn (difference modalities – verbal/printed)

Verify

- That the learning has actually occurred
- Use every encounter to help provide/reinforce the education

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Care Transition Improvement Techniques: Patient & Family Education

Medications & the Morisky scale

- Validated scale designed to estimate the risk of medication non-adherence
- Scores are based on patient responses to four, Yes or No questions
- Morisky Scale Questions:
  - Do you ever forget to take your medicine?
  - Are you careless at times about taking your medicine?
  - When you feel better, do you sometimes stop taking your medicine?
  - Sometimes if you feel worse when you take the medicine, do you stop taking it?
- Scoring the Morisky Scale Yes=0 and No=1
  - Zero is the lowest level of medication adherence
  - 4 is the highest level of medication adherence
  - Patients scoring 0 or 1 would benefit most from pharmacist intervention
  - Goal: screen for those in which your pharmacist time should be spent on enhancing adherence

Resource: Morisky DE, Green LW, Levine DW. Concurrent and predictive validity of a self-reported measure of medication adherence. Medical Care 1986;24:67-74.

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Care Transition Improvement Techniques: Patient & Family Education

Provide proper written description of all new medications

- Handout to patients

Support verbal education about medications with take-home, printed information sheets

- Review these with patient and family (consider size/language and font)

Key questions

- What else do you need in order to feel safe during your recovery at home?"
- What's the most important thing I can do for you as you prepare to go home?"
- What's something you really want to accomplish in your first week at home, and how can I help you reach that goal?

Encouraging a positive outlook

- "It won't be long before you'll…"
- "I like the way you listen to your body and what it needs…"
- "People like you don't usually take any longer than they need…in order to"
- "Slow but sure is often best… as you continue to recover"
- "Your wound is healing. The tissue is pink and clean…"

Resource: HCAHPS Breakthrough Webinar Series – Care Transitions Done Right

Care Transition Improvement Techniques: Patient Accountability

Teach what's needed for a safe transition

- Education for life after a hospital stay should not begin two hours before discharge
- Let patients/family know that when they leave the hospital they become, by default, their own Care Coordinator
- Encourage patients to assert that role, and tell health professionals what they need
- Teaching about diet, exercise, following medication regimens, etc. should be ongoing, daily

You'll know patients are self-reliant and ready for discharge when they:

- Participate actively in their care plan
- Know their diagnosis and prognosis
- Speak confidently about meds – aware of side effects
- Work with determination at PT, other therapies
- Have already set goals for rehab, recovery
- Are supported by knowledgeable family caregivers

Resource: HCAHPS Breakthrough Webinar Series – Care Transitions Done Right

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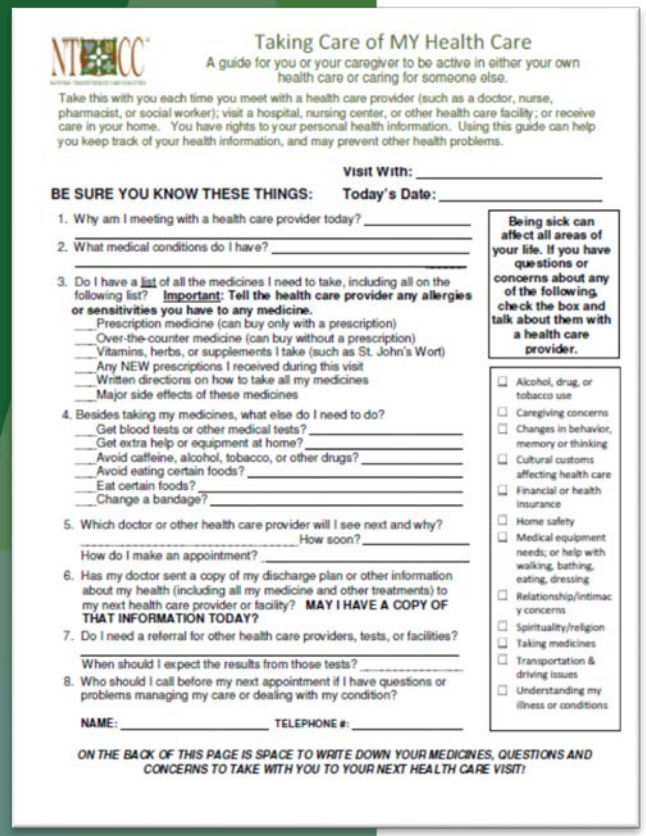
Care Transition Improvement Techniques: Patient Accountability Tools



NTOCC

Taking Care of MY Health Care

A guide for you or your caregiver to be active in either your own health care or caring for someone else.

Take this with you each time you meet with a health care provider (such as a doctor, nurse, pharmacist, or social worker); visit a hospital, nursing center, or other health care facility; or receive care in your home. You have rights to your personal health information. Using this guide can help you keep track of your health information, and may prevent other health problems.

Visit With: _____

BE SURE YOU KNOW THESE THINGS: Today's Date: _____

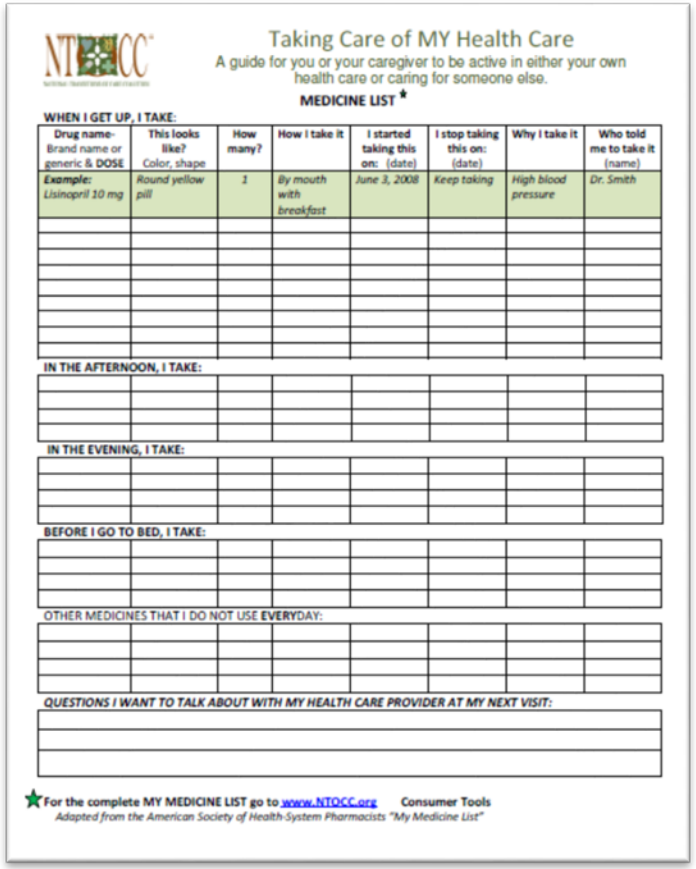
1. Why am I meeting with a health care provider today? _____
2. What medical conditions do I have? _____
3. Do I have a list of all the medicines I need to take, including all on the following list? **Important: Tell the health care provider any allergies or sensitivities you have to any medicine.**
   - ___Prescription medicine (can buy only with a prescription)
   - ___Over-the-counter medicine (can buy without a prescription)
   - ___Vitamins, herbs, or supplements I take (such as St. John's Wort)
   - ___Any NEW prescriptions I received during this visit
   - ___Written directions on how to take all my medicines
   - ___Major side effects of these medicines
4. Besides taking my medicines, what else do I need to do?
   - ___Get blood tests or other medical tests? _____
   - ___Get extra help or equipment at home? _____
   - ___Avoid caffeine, alcohol, tobacco, or other drugs? _____
   - ___Avoid eating certain foods? _____
   - ___Eat certain foods? _____
   - ___Change a bandage? _____
5. Which doctor or other health care provider will I see next and why? _____ How soon? _____
   How do I make an appointment? _____
6. Has my doctor sent a copy of my discharge plan or other information about my health (including all my medicine and other treatments) to my next health care provider or facility? **MAY I HAVE A COPY OF THAT INFORMATION TODAY?**
7. Do I need a referral for other health care providers, tests, or facilities? _____
   When should I expect the results from those tests? _____
8. Who should I call before my next appointment if I have questions or problems managing my care or dealing with my condition?

NAME: _____ TELEPHONE #: _____

Being sick can affect all areas of your life. If you have questions or concerns about any of the following, check the box and talk about them with a health care provider.

- ☐ Alcohol, drug, or tobacco use
- ☐ Caregiving concerns
- ☐ Changes in behavior, memory or thinking
- ☐ Cultural customs affecting health care
- ☐ Financial or health insurance
- ☐ Home safety
- ☐ Medical equipment needs; or help with walking, bathing, eating, dressing
- ☐ Relationship/intimacy concerns
- ☐ Spirituality/religion
- ☐ Taking medicines
- ☐ Transportation & driving issues
- ☐ Understanding my illness or conditions

ON THE BACK OF THIS PAGE IS SPACE TO WRITE DOWN YOUR MEDICINES, QUESTIONS AND CONCERNS TO TAKE WITH YOU TO YOUR NEXT HEALTH CARE VISIT!



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Taking Care of MY Health Care

A guide for you or your caregiver to be active in either your own health care or caring for someone else.

MEDICINE LIST ★

WHEN I GET UP, I TAKE:

Drug name- Brand name or generic & DOSE	This looks like? Color, shape	How many?	How I take it	I started taking this on: (date)	I stop taking this on: (date)	Why I take it	Who told me to take it (name)
Example: Lisinopril 10 mg	*Round yellow pill*	*1*	*By mouth with breakfast*	*June 3, 2008*	*Keep taking*	*High blood pressure*	*Dr. Smith*

IN THE AFTERNOON, I TAKE:

IN THE EVENING, I TAKE:

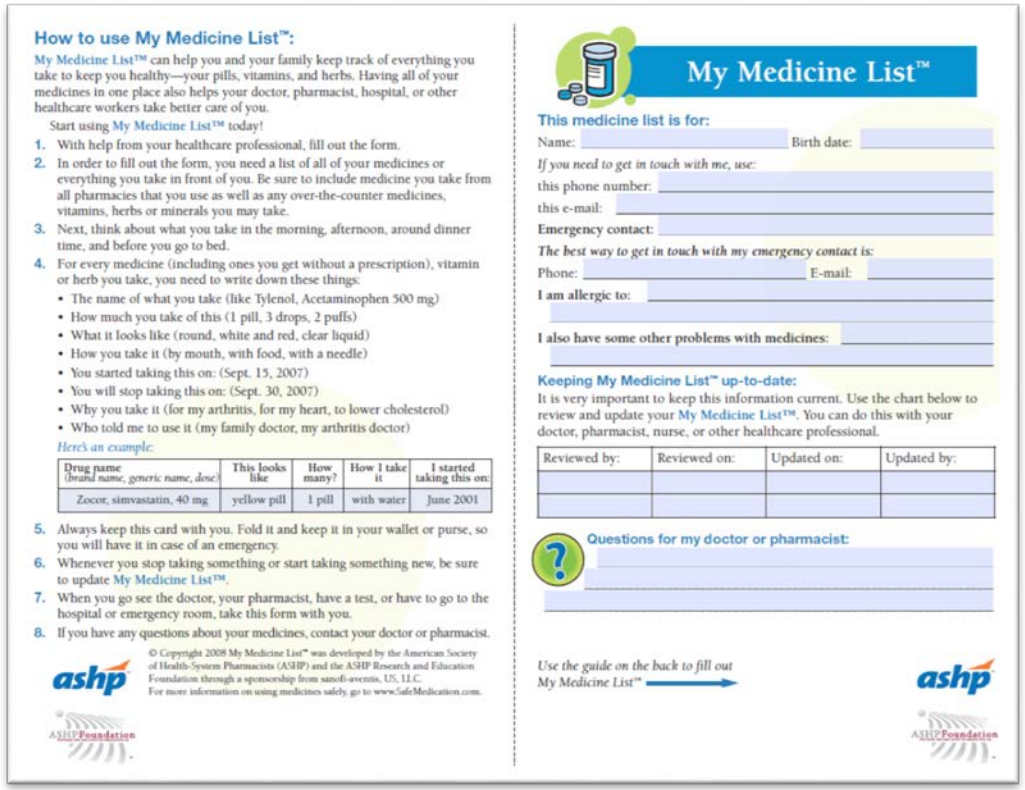
BEFORE I GO TO BED, I TAKE:

OTHER MEDICINES THAT I DO NOT USE **EVERYDAY:**

QUESTIONS I WANT TO TALK ABOUT WITH MY HEALTH CARE PROVIDER AT MY NEXT VISIT:

★ For the complete MY MEDICINE LIST go to www.NTOCC.org Consumer Tools

Adapted from the American Society of Health-System Pharmacists "My Medicine List"



How to use My Medicine List™:

My Medicine List™ can help you and your family keep track of everything you take to keep you healthy—your pills, vitamins, and herbs. Having all of your medicines in one place also helps your doctor, pharmacist, hospital, or other healthcare workers take better care of you.

Start using My Medicine List™ today!

1. With help from your healthcare professional, fill out the form.
2. In order to fill out the form, you need a list of all of your medicines or everything you take in front of you. Be sure to include medicine you take from all pharmacies that you use as well as any over-the-counter medicines, vitamins, herbs or minerals you may take.
3. Next, think about what you take in the morning, afternoon, around dinner time, and before you go to bed.
4. For every medicine (including ones you get without a prescription), vitamin or herb you take, you need to write down these things:
   - The name of what you take (like Tylenol, Acetaminophen 500 mg)
   - How much you take of this (1 pill, 3 drops, 2 puffs)
   - What it looks like (round, white and red, clear liquid)
   - How you take it (by mouth, with food, with a needle)
   - You started taking this on: (Sept. 15, 2007)
   - You will stop taking this on: (Sept. 30, 2007)
   - Why you take it (for my arthritis, for my heart, to lower cholesterol)
   - Who told me to use it (my family doctor, my arthritis doctor)

Here's an example:

Drug name (brand name, generic name, dose)	This looks like	How many?	How I take it	I started taking this on:
Zocor, simvastatin, 40 mg	yellow pill	1 pill	with water	June 2001

5. Always keep this card with you. Fold it and keep it in your wallet or purse, so you will have it in case of an emergency.
6. Whenever you stop taking something or start taking something new, be sure to update My Medicine List™.
7. When you go see the doctor, your pharmacist, have a test, or have to go to the hospital or emergency room, take this form with you.
8. If you have any questions about your medicines, contact your doctor or pharmacist.

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ASHP Foundation

My Medicine List™

This medicine list is for:

Name: _____ Birth date: _____

If you need to get in touch with me, use:

this phone number: _____

this e-mail: _____

Emergency contact: _____

The best way to get in touch with my emergency contact is:

Phone: _____ E-mail: _____

I am allergic to: _____

I also have some other problems with medicines: _____

Keeping My Medicine List™ up-to-date:

It is very important to keep this information current. Use the chart below to review and update your My Medicine List™. You can do this with your doctor, pharmacist, nurse, or other healthcare professional.

Reviewed by:	Reviewed on:	Updated on:	Updated by:

Questions for my doctor or pharmacist:

Use the guide on the back to fill out My Medicine List™ →

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Care Transition Improvement Techniques: Standardization & Process Map

- Examine your **internal discharge process** from start to finish
- Identify the **path** that most of your patients take after they leave the facility
- Work with an **interdisciplinary team** with staff from both settings (if another facility) or with a patient and family group (if home)
- Start with a **process map** of the specific steps in the current process
- Identify **opportunities** for improvement and "if this, then…"
- Look for areas of verbal and written/electronic **handoff**
- Create **checklists** of what needs to be done & communicated at each step
- Draw the **future state** or improved current state process map

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Resource: Relias Learning Webinar on Care Transitions: implementing Proper Transitions of Care to Prevent Rehospitalization. Retrieved from https://www.reliaslearnign.com/resource/implementing-proper-transitions-of-care

Value Stream Mapping: St. Mary's Sacred Heart

- Completed a process flow chart from a clinical manager perspective
- Met with front line staff to add their perspective to the process flow
- Presented it to post acute resources at quarterly meeting to see what they could add

➢ All of this in an effort to identify areas of improvement from all eyes across the spectrum

Goal: Identifying opportunities to improve transitions of care from all depts (housekeeping, food/nutrition, etc.) and working on some scripting for them

What questions do you have for me?

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612-805-1323

Care Transitions: Additional Resources

AHRQ Developed Strategy 4: Care Transitions From Hospital to Home: IDEAL Discharge Planning highlights the key elements of engaging the patient and family in discharge planning:

- Include the patient and family as full partners in the discharge planning process
- Discuss with the patient and family five key areas to prevent problems at home:
  - Describe what life at home will be like
  - Review medications
  - Highlight warning signs and problems
  - Explain test results
  - Make follow-up appointments
- Educate the patient and family in plain language about the patient's condition, the discharge process, and next steps at every opportunity throughout the hospital stay
- Assess how well doctors and nurses explain the diagnosis, condition, and next steps in the patient's care to the patient and family and use teach back
- Listen to and honor the patient and family's goals, preferences, observations, and concerns

Resource: AHRQ. Strategy 4: Care Transitions From Hospital to Home: IDEAL Discharge Planning. Retrieved from https://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy4/index.html

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Care Transitions: Additional Resources

Improving Transitions from the Hospital to Post-Acute Care Settings to Reduce Avoidable Rehospitalizations
Institute for Healthcare Improvement - How-to Guide Summary

Key Changes to Create an Ideal Transition Home

1. Perform an Enhanced Assessment of Post-Hospital Needs A. Involve the patient, family caregivers, and community providers as full partners in completing a needs assessment of the patient's home-going needs. B. Reconcile medications upon admission. C. Identify the patient's initial risk of readmission. D. Create a customized discharge plan based on the assessment.	**3. Ensure Post-Hospital Care Follow-up** A. Reassess the patient's medical and social risk for readmission. B. Prior to discharge, schedule timely follow-up care and initiate clinical and social services as indicated from the assessment of post-hospital needs.
2. Provide Effective Teaching and Facilitate Enhanced Learning A. Involve all learners in patient education. B. Redesign the patient education process. C. Redesign patient teaching print materials. D. 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.	**4. Provide Real-Time Handover Communications** A. Give patient and family members a patient-friendly post-hospital care plan that includes a clear medication list. B. Provide customized, real-time critical information to the next clinical care provider(s). C. For high-risk patients, a clinician calls the individual(s) listed as the patient's next clinical care provider(s) to discuss the patient's status and plan of care.

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Resource: Institute for Healthcare Improvement. Improving Transitions from the Hospital to Post-Acute Care Settings to Reduce Avoidable Rehospitalizations Institute for Healthcare Improvement - How-to Guide Summary Retrieved from http://www.ihi.org/topics/CMSPartnershipForPatients/Documents/IHI_TransitionsHowtoGuides_Summary_Aug11.pdf