TENNESSEE HOSPITAL ASSOCIATION

Care Transitions Coordinator Coalition

September 2016 – *Roster of Attendees*

Post-Discharge Communications with Patients and Families

Below, in no particular order, is a list of ideas and strategies identified by the Coalition as the most valuable of those discussed amongst representatives present at the September 2016 meeting. While the topic of the meeting was post-discharge communications with patients and families, ideas and strategies for related work arose and are included in this document. For more information, contact Rhonda Dickman at THA: 615-401-7404 or rdickman@tha.com

Patient and Family Education

- Build education around patient's preferences and goals
- Assess patient and family learning methods
- Engage patients and families in education by utilizing teach-back
    - Observe staff performing teach-back with patients and families to assess their practice; provide feedback on what was done well and where there are opportunities for improvement.
- Consolidate patient education materials
    - Try to keep information within 1-2 pages
    - *See Appendix A – Consolidated Care Note from NorthCrest Medical Center*
- Align teaching materials/messages both internally and with community partners to ensure consistency across the care continuum
- Provide patient and family education earlier in the hospital stay to avoid overload at time of discharge
    - See high-risk patients, such as CHF or COPD, while in the Emergency Department
    - Begin preparing for discharge from the day of admission
- Conduct bedside rounds to keep patients and families engaged in learning about their condition, participating in their treatment plan, and planning for discharge
- Design and print refrigerator magnets with key education points for patients and families to use at home
    - *See Appendix B – Refrigerator Magnets from Cookeville Regional Medical Center*
- Integrate interactive components to patient education materials, such as crossword puzzles, word games, or coloring

Post-Discharge Phone Calls

- Place an initial call within 48 hours of discharge

- Personalize the calls and make them relational
- Present and maintain an attitude of caring service, letting patients and families know it was "my pleasure" to be of assistance
- Identify and utilize patient's preferred method and timing of communication
- Utilize trained students and/or volunteers to make calls and triage identified needs to appropriate staff for follow-up
    - *See Appendix C –Volunteer Phone Script from Methodist LeBonheur Germantown Hospital*
- Utilize existing resources such as call center staff for follow-up phone calls, providing scripts and training
- Place at least three follow-up calls within 30 days of discharge
- Coordinate patient and family follow-up calls between hospital and primary care provider's office
- Talk with patient and family about follow-up phone calls before patient is discharged, stressing the importance of participation
- Consider use of an automated calling system to expand care transition coordinator outreach
    - Select a system that is customizable to patient needs
    - Provide personal, face-to-face patient and family orientation to the call system prior to discharge, utilizing demonstration and teach back
        - Provide number that will appear in Caller ID screen with automated call
        - Obtain best phone number to utilize for calls
    - Provide prompt follow-up calls to flagged areas of need

Communication with Providers

- Utilize night-shift staff to fax discharge paperwork to the physicians, both primary care provider and consulted specialists, for patients discharged that day
- Notify the patient's primary care provider of their hospitalization while the patient is still in the hospital
- Increase collaboration with skilled nursing facilities and other post-acute providers
    - Warm hand-offs
    - Special focus on medication orders
    - Coordinate patient and family follow-up communications after discharge from their service/facility
    - Provide report cards to post-acute providers and discuss trends or issues
    - Conduct regular meetings with post-acute providers to discuss care transition processes and opportunities for improvement
- Participate in your region's Care Transition Community meetings

Other Key Practices

- Provide contact information to a care transition coordinator or other resource for calling with questions or concerns
    - *See Appendix D – Letter from Outcomes Coordinator from Methodist LeBonheur Germantown Hospital*

- Establish a free Transitional Care Clinic that reinforces patient and family education on their health condition and treatment plan, and addresses potential readmission risk factors
- Conduct post-discharge support groups for high-risk diagnosis groups
    - *See Appendix E – Harmonicas for Health from the COPD Foundation with St Thomas Rutherford Hospital*
- Implement a readmission risk scoring methodology during hospitalization to more efficiently allocate care transition coordinator resources
- Evaluate utilization of home care services to determine if they are underutilized
    - Hospitalist or ER physician order one face-to-face home care appointment for patient while waiting for primary care provider order
- Multidisciplinary discharge rounds that include patient and family
    - Schedule ahead of time so family can make arrangements to attend, if possible, and team members will be prepared for the discussion
- Use patient feedback to improve discharge and care transition processes
    - HCAPS survey findings
    - Reported complaints or compliments
    - Patient Family Advisory Council input
- Use social workers, or individuals trained in health coaching or motivational interviewing, to design an effective approach to patient and family engagement in treatment and discharge plans
- Remember to provide support to caregivers since patient outcomes tie directly to compassion fatigue
    - *See Appendix F – Three Good Things from Duke University*
    - *See Appendix G – The Starfish Story, adapted from The Star Thrower, by Loren Eiseley (1907 – 1977)*