Provide Real-time Handover Communications

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These presenters have nothing to disclose.

Session Objectives

Participants will be able to:

- Provide an overview of this key change.
- Discuss strategies for testing and implementing this key change.
- Provide an introduction to action planning for this key change, including designing reliable processes as well as testing and using process measures.

Provide Real-Time Handover Communications

- There are a vital few critical elements of patient information that should be available at the time of discharge to community providers ("senders" and "receivers" agree upon the information and design reliable processes)
- Written handover communication for high risk patients is insufficient; direct verbal communication allows for inquiry and clarification
- Consider designing standardized handover forms for the community, region or state
- Written care plans for patients and family caregivers should use clear, user-friendly formats for describing care at home

Real-time Handover Communication

Typical Failures

- Medication discrepancies
- Discharge plan not communicated in a timely fashion or adequately conveying important anticipated next steps
- Discharge instructions missing, inadequate, incomplete, or illegible
- Current and baseline functional status of patient not described, making it difficult to assess progress and prognosis

Real-time Handover Communication

Typical Failures (cont.)

- Patient returning home without essential equipment
- Care processes unraveling as the patient leaves the Hospital (e.g. poorly understood cognition issues emerge and the patient is no longer able to manage medications or family caregiver is no longer available)
- Lack of appreciation for weakness of patient's social support and financial implication of the cost and access to medications

Real-time Handover Communication

Changes

A. Reconcile medications at discharge

B. Provide customized, real-time critical information to the next clinical care provider(s)

C. Give patients and family members a patient-friendly discharge plan

D. For high-risk patients, a clinician calls the individual listed as the patient's emergency contact to discuss the patient's status and plan of care

Real-time Handover Communication

A. Reconcile medications at discharge

- Review the patient's pre-hospital and hospital medication regimen
  - Consider additional information that was not evident at the time of admission
  - Clarify whether medications that have been withheld should be restarted after discharge or not
  - Reconcile substitutions from the institution's formulary and translate back to the original preparations to avoid duplication, medication errors, or unnecessary expense to the patient
  - Convert hospital intravenous medications to oral medications

Real-time Handover Communication

A. Reconcile medications at discharge

— Communicate clearly to the patient, family caregiver, and next care team:

- Names of each medication, reason to take it
- New medications and pre-hospital medications the patient is to discontinue
- Whether there are any recommended changes in the dose or frequency from pre-hospital instructions
- Pre-hospital medications to be continued with the same instructions
- Medications and over-the-counter medications that should not be taken

Reconcile Medications

- Can the patient:
  - Read their medication labels?
  - Afford the necessary medications and foods?
  - Get to a Pharmacy?
- Use highlighting on meds list to call attention to new medications or changes
- Encourage patients and families to use a tool or document that does not require reliance on memory such as personalized medication list

Real-time Handover Communication

B. Provide customized, real-time critical information to next clinical care provider(s)
   - Patient's baseline functional status
   - Active medical and behavioral problem
   - Medication regimen
   - Plan of care with goals
   - Pending labs and other tests
   - Family or social support resources
   - Ability and confidence for self-care
   - Medical equipment needs

Opportunities for Improvement

- 81% of patients requiring assistance with basic functional needs failed to have a home care referral
- 64% said no one at the hospital talked to them about managing their care at home

Clark PA. Patient Satisfaction and Discharge Process: Evidence-Based Best Practice. Marblehead, MA: HCPro, Inc., 2006

Barriers to Efficient Transitions

- The two settings agree that better communication and better education management, including support for discharge planners, are highly likely to reduce readmissions
  - ***Yet***, less than 9% of Hospitals and 14% of SNF's reported regular meetings or hold multiple facility transition of care meetings to discuss cases or processes

Real-Time Handover Communication

"Don't confuse information with communication." ~ Eric A. Coleman, MD, MPH

- Evaluate your current discharge communication tools and discharge summaries (see observation guidance)

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Real-Time Handover Communication

Patients going to community facility:

- Alert next care providers to patient's discharge readiness and needs post discharge
- Nursing home or SNF liaison with hospital
- Ask receiving care teams for their preferred format, mode of communication and specific information needs about patient's functional status.
- Share patient education materials and educational processes across all care settings

Mor et al; The Revolving Door of Rehospitalization from Skilled Nursing Facilities

Health Affairs *Jan. 2010 29:1*

- Almost one-fourth of Medicare beneficiaries discharged from the hospital to a skilled nursing facility were readmitted to the hospital within thirty days; this cost Medicare $4.34 billion in 2006
- The overall rate increased from 18.2% in 2000 to more that 23.5% in 2006

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Case Management Monthly
Reducing Hospital-SNF 30-day Readmission

- Findings from 931 hospitals and SNF interviews in 2009 indicated that 30-day hospital readmission could be reduced if:
  - SNF had better access to hospital staff and documentation
  - Medication changes for non-medical or formulary reasons were minimized as patients transition between settings

Long-Term Care/Skilled Nursing Facility/Home Care

- Patient education is sent with all nursing home patients at discharge.
- Home care uses same education material as hospital.
- Educational offerings for the staff conducted in the LTC/SNF/Home Care Agencies
- Long-term care/Skilled Nursing Facility/Home Care representative added to our Transition to Home team

St Luke's Hospital, Cedar Rapids, Iowa

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Real-time Handover Communication

C. Give patients and family members a patient-friendly discharge plan:

- What to expect at home
- Self-care activities
- Medication card with current medications
- Reasons to call for help
- Numbers for emergent needs and non-emergent questions
- Explore Community Support systems (e.g. Aging Services, Community Centers)

Patients going home:

Give Patients a “Patient Friendly Discharge Preparation Checklist“

- Involvement in decisions
- Understanding of where I’m going
- Who to call if problems arise
- Understanding of medications, side effects
- Symptoms to watch for
- How to keep from getting worse
- Someone knows I’m coming home
- Have follow-up appointment and transportation

http://www.caretransitions.org/transitionskills.asp

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Patients going home:

- Assure patient and key learner are present for discharge instructions
  - Easy-to-read self-care instructions
  - What to expect at home
  - Medication card with current medications
  - Reasons to call for help
  - Numbers for emergent needs and non-emergent questions- consider one number to call
  - Inform patient what information to take to their follow up appointments

Resources for Tailoring Medication Lists

- How to Create a Pill Card
  http://www.ahrq.gov/qual/pillcard/pillcard.htm

- Iowa Healthcare Collaborative (IHC) Med Card

http://www.ihconline.org/aspx/consumerresources.aspx#MedCard_Anchor

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User-Friendly Medication Card (IHC)

Personal Medicine Record for:_____

- Use a pencil.
- Do not list medicines I will take for less than two weeks (example: antibiotics).
- List all medicines I take, including prescriptions, eye drops, inhalers/nebulizers, oxygen, creams and ointments, birth control pills, etc.

Date added or changed	Medicine	How much? (Strength/ Dosage)	How often do I take it?	What is it for?	Doctor who prescribed it

Over-the-Counter Medicines (medicines you can buy without a doctor's order): (Check all that you use regularly.)

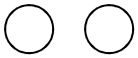
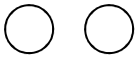
- ☐ Allergy medicine, antihistamines
- ☐ Antacids (for heartburn or stomach)
- ☐ Aspirin
- ☐ Cold/cough medicines
- ☐ Diet pills
- ☐ Herbals, dietary supplements, hormones
- ☐ Laxatives
- ☐ Sleeping pills
- ☐ Vitamins, minerals
- ☐ Pain, headache or fever medicine
- ☐ Other (List):_____
  _____

Taking Care of Myself:
A Guide for When I Leave the Hospital

AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

How to Create A Pill Card (AHRQ)

Name: Sarah Smith **Date Created: 12/15/07**
Pharmacy phone number: 123-456-7890

Name	Used For	Instructions	Morning 	Afternoon 	Evening 	Night 
Simvastatin 20mg 	Cholesterol	Take 1 pill at night				
Furosemide 20mg 	Fluid	Take 2 pills in the morning and 2 pills in the evening				
Insulin 70/30 	Diabetes (Sugar) 	Inject 24 units before breakfast and 12 units before dinner	24 units 		12 units 	

Real-time Handover Communication

D. For high-risk patients:

- A clinician calls the individual listed as the patient's emergency contact to discuss the patient's status and plan of care
- Provide opportunities for the patient/family caregivers or the next level of care provider to review instructions, clarify and ask questions even after the patient has been discharged

Real-time Handover Communication

- Speak with the patient-identified family caregiver listed on the medical record before or immediately after discharge and provide critical information on patient safety
- Share patient education materials and education processes with next care settings

Establish Cross-Venue or Continuum Collaboration

- Develop creative solutions for bi-directional communication and feedback processes, coordination and greater understanding of patient needs
- Continually improve by aggregating the experience of patients, families, and caregivers and designing improvements

Identify Opportunities

- Observe patients and staff during discharge handovers
- Seek information on usefulness of handover information
- Exchange visits with community partners: “Go See” and observe together
- Review cases of readmitted patients with community providers
- Interview readmitted patients and their families: what didn’t work well?

Process Measure Examples

Customized Handover Communications:

- Percent of patients discharged who receive a customized care plan written in patient-friendly language at the time of discharge
  - (no jargon, plain language, what patients must know and do at home to stay safe)
- Percent of time critical information is transmitted at the time of discharge to the next site of care
  - (e.g., home health, long term care facility, rehab care, physician office)

What are we learning about real-time handover communications?

- There are a vital few critical elements of patient information that should be available at the time of discharge to community providers for every patient that is discharged from the hospital. Yet the vital few are not proven.
- Written care plans for patients and family caregivers should use clear, user-friendly formats for describing care at home.
- Written handover communication for high-risk patients is insufficient; direct verbal communication allows for inquiry and clarification.
- Complexity of handovers suggests we need to consider standardized handover forms for the community, region or state.