The Re-Designed Discharge Process:
Patient Discharge and Follow-up Care, Module 3

An Agency for Healthcare Research and Quality webinar presented by Karla Weng, Stratis Health program manager. Third in a series of modules on care transitions and discharge planning, Module 3 focuses on patients who don't have a primary care physician, the process for completing a patient care plan, and conducting patient education, teach back, and follow-up. (79-minute webinar) 10-30-2012

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Please stand by for real time captions.

Conference Operator: Ladies & gentlemen, thank you for holding. Your conference will begin in approximately two minutes.

Good afternoon ladies and gentlemen. Thank you for waiting. Welcome to the Stratis Health Project Red Module 3 Conference Call. All-conference lines will be open for interaction with your host. Should you need to mute or unmute your line any time, you may press *-asterisk star six to do so. Without further ado, it is my pleasure to turn the floor over to your host.

Good afternoon everyone, this is Karla Weng with Stratis Health. We are going to go ahead and have the lines open and hopefully have a good discussion today. This is Module 3 of the Project Red Collaborative. We have a little bit of a late start, hoping to have a couple of other folks join us. I am sitting in today for Kim McCoy. We will start with introductions of who is on the phone and who is in the room with me. So, Sam? Do you want to pick that up?

Okay. Hi this is Sam from Regions.

This is Nancy Miller from Regions.

Renee Lewis, Regions.

[Indiscernible]

Okay, thank you for the team at Regions. What about Deidre? Anyone there with you?
No, just me.

All right. Thank you for joining us.

Looks like someone else joined us as well?

Can we talk?

I think you missed Josh Brewster from Regions.

Did I hear anybody from Fairview Range?

Neil Walker, Fairview Range.

Fairview Range is here in a group also can you hear us?

Yes.

We don't actually know how to use the telephone speaker so we are talking in event of the.

Okay there is a group for me there?

Yes we have Ivy, Stephen Kristofferson, Penny, Cal, Gery.

All right. Anyone from HCMC? Or Buffalo? Okay. Welcome everyone. I am pleased to be with you today. We will do a quick review of the accomplishments to date, sort of looking at Module 1, and jump into the next phase of the work. We will talk about what is next as you work through this process at your organization. Does anyone have a question for me as we are kicking that off? Okay. So, Module 1, if I remember right, we launched this with a WebEx in August. Module 1 really starts with a focus on the process method, the current discharge process with your primary care practitioner referral, where you will focus for the start of your Project Red work. You will be looking at a patient care plan and structure and as a project implementation piece you have in your project charter and issued or whatever format your organization uses and that you have started to think about when you might want to do some training for front-line staff.

In Module 2, which was the last discussion about a month ago, was starting to look at project metrics which you might want to measure, how you might want to collect that information, starting to look at patients you might want to include, where you will focus in particular. We encourage you to start this work with the pilot, the process for identifying those patients and notifying a discharge advocate. I would also add that there really needs to be a discussion about who in your organization is going to fill the discharge advocate role. We have seen lots of different models for how people cover that role, whether an individual staff or shared staffing and how that works. Also, think about multidisciplinary involvement and communications, as well as how the patient care plan process is going to work.

Hoping to take a few minutes now and hear how that work has been going, where you are on the Module 1 and Module 2 steps. In particular, who are you thinking might fill your discharge advocate role? What patients will you focus on? Where are you with the patient care plan process? Does anyone want to jump in on any of those questions?
Hi, this is Sam from Regions. In our pilot project, around mental health, we are looking at the corridor and workflow documentation that some work needs to be done to update some of the workflows. But, in essence, the leader, the director of the group has given us the go-ahead for the pilot. So we are gathering information as we speak. We also have Nancy Miller, who happens to be a direct contributor to that group. Nancy?

This isn't Nancy -- this is Josh -- (laughter) a lot of work has been done by the mental health group to look at the discharge process and adjust the entire flow of patients as they move through the system. Some of this is in connection to our move to a new building and it is a perfect time for culture change, but a lot of work has gone into mapping the current processes, where there are opportunities, who was involved, when, doing what, what kind of indication is happening, but this Project Red will allow the work to be taken to the next level.

That sounds like it sort of fits altogether. Have you had any thoughts about how you might fill that role of the discharge advocate? Who kind of oversees the process to make sure that pieces are in place for each of the patients?

Currently, all of the mental health patients are seen by a social worker and assigned a social worker. So, we are thinking probably that role will tie with some nursing.

We've seen a real mix from a lot of the different hospitals. One organization was focusing on COPD so they decided it made sense for the respiratory therapist to be in the role. So, you need to look at your patient population and what makes sense. The important pieces of the role are covered and they are getting done, not always necessarily which discipline is the one doing it. Excellent. Thank you. What about Fairview Range or Madelia? How are things going there?

At Madelia, for Project Red we already have a couple of things we need to work on, specifically going home instructions, and we pulled our pharmacist in who is going to help with doing the med reconciliation on discharge. And, we just recently, the first of September, hired our own physician because we have been kind of in transition. I have been meeting with her and she is going to be taking an active part, but we are kind of in the midst of things. So --

Good. I would guess, I think a lot of folks start to look at this and realize you have a lot of pieces in place. It is a matter of drawing the line between them, making sure it is done in a systematic manner.

Correct.

Great. How about Fairview Range?

Yes, this is Penny Kelger. Can you hear me?

Yes.

We have started a pilot with pneumonia, COPD, -- page of our care management consists of two social workers and one RN, so the RN is our discharge advocate and is responsible for picking up on those three diagnoses and doing the core measure, teaching, etc., and making sure pieces are in place. And our pharmacy has also started seeing our patients on the second day of admission, doing instructions for patients and trying to pick up on as many a discharge as well
for high-risk medication, teaching, we also started doing follow-up phone calls, 48 to 72 hours on the three diagnoses I mentioned.

Excellent. And how is that all going?

Pretty well I think. (laughter) It is kind of a work in progress, we are trying to beef up our daily interdisciplinary meetings to kind of focus in more on the plan and start trying to frontload it a little more as far as planning.

Good. That is one of the reasons we encourage a pilot. These things are a work in progress. Starting out small gives you a chance to figure out some of those things as you go forward.

Yes. We are just starting to ramp up for our go live 2, a lot of effort going into that trying to muddle through until we get through that.

Okay. Without probably answers my next question for Fairview Range, but how are things going with the patient care plan and what actually comes out -- what you are able to provide your patients for their patient instructions going on? In the experience I have had with working with hospitals in Project Red so many folks are in the midst of a transition or perhaps they can't get exactly what they want out of the system, so I know that, a lot of times, has been a challenge and how is that going at Regions or Madelia?

[Indiscernible] at regions is currently under redesign but our [Indiscernible--static] team [Indiscernible--low volume] see what we can do. Our clinics had a redesign a few months ago so the hospitals are now patterning after what the clinics have done so our patients see the same information, it looks the same. They know where to look for contact.

Good. How about at Madelia?

We have issues with our EMR and med reconciliation. So I think we are going to have a little bit more work right now and try to use some of the other tools and resources that we've gotten from you guys, but we will be going to a different web-based form of our health EMR in June of I think next year. So, we may see some good things come out of that, but for the time being, I think we are going to be doing a little bit extra work to get it altogether.

Yes, you are not the first I have heard. There have been a few that have known that rollover is going to happen 12 months from now, but they want to do something in the short term, so maybe they are using a PowerPoint template or word template, doing extra data entry in a more friendly format for their patients.

Right.

Good. One last question and we will jump to Module 3. Anything surprise you? Good or bad in the work you have done so far? Or has it all gone as you have expected?

I think for us at Madelia, I am the one that does [Indiscernible] for Stratis for CHF, pneumonia and so I know where the holes are and I have not been real surprised. But excited about the tools and how we can fill some of those holes. It will be good.

Okay. Thank you. Anyone else? Any surprises as you have been working through this?
This is Neil at Fairview Range pharmacy. I think the pharmacy [Indiscernible] up there with the same number patients to see every day, would probably be more manageable instead of having 2 one day and 15 another day. Difficult to see new additions on a brief visit the day after, and see the high risk discharges, disease specific or again the insulin. New Coumadin patients too.

That workload is never quite steady, is it? Good. Well, I am happy to hear about the pharmacy involvement on both ends. The original Project Red at Boston Medical was very heavy with pharmacy involvement. They even had the pharmacist implement the follow-up phone calls. So, I know in most health care systems the pharmacy resource is a little more scarce. Folks maybe aren't able to have them involved to that extent, but the more the pharmacy can be involved in patient teaching and be available for the questions, the better I think. Excellent.

So please feel free as I start to walk through the Module 3 to stop me if you have questions. I have the lines open so ask them. If you have observations you want to share that too. I have a special spot specifically to talk about that but also want to have your input as we go as well. So we will jump into Module 3. This kind of moves and some of you who are a bit beyond this where you are out in the workplace, work through the progression. One of the areas to focus on thinking about is what do you do when you have patients that don't have a primary care physician? What is your process for identifying them or looking up primary care physicians for follow-up? I am guessing for some of you this is a bigger issue than others depending on the patient population you serve. Identifying resources for patient information, thinking about how you are completing discharge preparation around medication reconciliation, pending tests, follow-up appointments, how you will communicate that time with the primary care physician, finalizing the care plan and completing and printing it, getting into the patient, how you are conducting teach back with the patient and family. We will really focus in on all that today in our discussion, and finalizing the process for making the post discharge call.

So, again, we will talk about completing of the patient care plan, teaching and teach back. I have a piece I have inserted into this focusing on health literacy and why that is so important. With the post discharge activities, follow-up connection with PCP and how you will manage process and think about your training staff.

So, this diagram will look familiar to you. When you talked with Trent and Kim last time -- Gmail and Kim B focused on the last side of the diagram patient admission, with a command when you start to build that in Module 3. The focus is now on the second half of that patient stay. So, the discharge orders are written, you get into the actual discharge process and actual discharge event and follow-up. When you think about a whole hospital stay, that is where Module 3 really focuses in from about halfway through, about the point where you think they are ready for discharge to the post discharge follow-up.

So what fits into this? Here are the 11 components of Project Red we have been pounding into you. They are the key components we are focusing on today: follow-up appointment and outstanding test, making sure the patient has that information and knows what to do. The written discharge plan makes sure there is an understanding for the patient and family of what to do when a problem arises. Help getting in front of those problems may be a call to the physician earlier versus a return back to the emergency department later.

Assessing patient understanding, making sure the discharge summary is linked up and sent to the PCP and the telephone reinforcement. That is how that fits into the 11 components of where we
are headed today. Sorry, apparently I did not go to the slide in presentation mode and did not know I had depressed them all at the same time.

We will go through the patient care plan. It sounds like some of you are in transition with medical records and how this is flowing together. I really want you to consider at this point, there are lots of technical details about how the patient care plans come together, but really what the discharge advocate role is in completing the patient care plan -- focusing from that lens. So what is the role of medication reconciliation? Following up on pending tests? Post discharge, the link to the PCP and how they get that information out? So, from the medication reconciliation consideration, when you are looking at it from the discharge of the kit lens, depending on how the discharge advocate fits into the process of medication reconciliation among hospital procedure, it is really their role to participate and conduct a final check. Be sure the final check has been done and that is what is being used to populate the patient care plan and that the final list is used to instruct the patient.

I know this is an ideal situation into there are signs that medications change at the very end of a stay but from an advocate role it is really focusing in on is the medication reconciliation complete and is this the most complete, appropriate list to make sure we are doing our education with. Does that make sense? And, does that seem like something that your discharge advocate can do when you are thinking about a social worker role?

Next step for discharge advocates when completing the patient care plan is really focusing in on pending tests and results. Making sure that information about tests and studies are completed that our results pending, that information is included in the patient care plan and making sure that is being adequately communicated with the patient. Making sure the patient understands that test results are waiting and which clinician is responsible for getting them and where they can follow-up also, then an encouragement to discuss the tests of the primary care physician and that information. Pointing to that information now where it is in the patient care plan, again as the advocate role is kind of overseeing, making sure those pieces are complete and the information is available before discharge.

For post discharge services, depending on how you are structuring this role, the discharge advocate might be the one who is actually arranging the services. But if they are not, confirming with your case manager, discharge plan, or social worker, whoever is in the role, that services have been arranged and the service information and contact information is clearly listed in the patient care plan. Again, are all the pieces together versus maybe the person actually doing them all themselves? Depends on how you structure the role. Confirming the name of the primary care provider, making sure the information is in the patient care plan as well as the contact number. Particularly for those patients who don't have a regular primary care provider, this is where the process of what to do with them will play and how you line them up for follow-up after hospitalization can be such an important part of care, which then leads us to the follow-up appointments.

Ideally, making that appointment with patient input before they leave the hospital is a terrific way to do it if that is feasible. Understanding what days of the week and times of day work for the patients, what the transportation needs might be, it is great if you make their appointments--but if you make the appointment on Wednesday at 10:00 and they know they don't have somebody to drive them to the physician office that day, you wasted an appointment at the clinic and have not helped the patient. Trying to understand both when they might be available and how to get there as well as making the appointment is ideal. We've seen a mix of how folks have
done this particularly for those in integrated systems. It depends on who the primary care physician base is on how you work with them, but ideally that follow-up appointment as well as some discussion about how they need to get there should be part of the discharge discussion.

So, finally, the last piece of this is how they get information about the condition to that patient. Where are you pulling your patient education information, and make sure it is clear when you have the signs and symptoms that warrant follow-up or emergency care. I think there is a tendency to focus on getting them all the information possible versus highlighting the pieces that are really important. Somehow we can slim that down to get the vital few pieces of information to them and focus on having that available in the patient care plan.

What you really want to end up with is a patient care plan that has these sections completed: date of discharge, name and contact information for the physician and the discharge advocate or whoever it is at the hospital that is available for that person to call with questions. How to reach the physician, and when and how to seek emergency care. I would actually highlight this one in a separate bullet because I think this is important--it can't be understated in making sure the patient and family understand what the red flags are, so they can call and know what they need to do.

Medication, always a challenge to make sure good, accurate information is there, as understandable as possible. If someone has multiple follow-up appointments or a more complex follow-up schedule, a calendar might be a nice way to do this particularly if you have other services coming in, durable medical equipment, home care, those sorts of things--any other orders around diet and activity, basic education around disease or condition. Some folks really like to have a place right on the care plan where they can write down the questions and depending on the complexity of the facility and size, we have seen maps for locating appointments with a map of the campus and circled where they need to be and other information you want to include about your facility.

So, when you think about the patient care plan and where you are with that process, have you been able to get all of those content areas included in the final patient care plan template?

This is Regions. Yes, we have all of that currently available to the patient after the visit summary or discharge plan. What we are doing now is working to make it much more patient friendly, and clearer for them to read.

Yes. That is an important distinction. A lot of times all the information might be in 20 pages. Hand them something that is clear and easy-to-read. Thank you for bringing that up. Have folks thought about how the discharge advocate role fits into making sure the patient care plan is complete? Okay. I know that some of the Project Red lists use discharge advocate as the language, but I really like advocate role because I think that is what it is, advocating for the patient to make sure they have all the information and resources available for them. Do you see any gaps that still need to be addressed in your patient care plan? Sounds like Regions is going to redesign on the patient friendly side -- how about Madelia or Fairview Range?

This is Deidre at Madelia. I don't know that we see any gaps -- we have discussed doing a binder. We have issues with patients going to a provider, like in a specialty clinic, and they are supposed to have lab work drawn. The specialty clinic does not have it, so, we are talking about doing a binder for the patient and giving them copies of their lab work so when they do go to other appointments, they've got it all together. So, this is where we are going to start with this population for Project Red. Just trying to fine tune all of it.
Good. Good. I know that some other small, rural hospitals have had some success. Granite Falls in particular has a traveling patient care plan in a three ring binder. They are often perhaps going outside their community to see a specialist, one way to help them have that information together.

Yes.

Okay. Excellent. So, we are going to jump a little bit. I actually pulled in some slides from the Minnesota Health Literacy Partnership. We are going to talk a little bit about health literacy. In particular how it ties back to the importance of teach back and having patient friendly materials. Some of you might be well versed in this. You can go to conferences on health literacy, a pretty big topic. I think I have five slides, we will do the speed version of health literacy but I think it is an important context when thinking about how you are working with your staff in rolling out the concept of teach back in particular. The most common definition that you have probably seen around health literacy, if you have seen one, actually is not the one on the slide. It is actually from Healthy People 2010 in an article in 2000. The most commonly mentioned definition of health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions—which is very much a patient or individual focused definition. The Minnesota Health Literacy Partnership is an umbrella organization of provider groups, health plans, the Literacy Council--basically anybody interested in health literacy issues. It actually expanded the definition some and I like the focus on it because it is usually the angle that providers are looking at. Both the patient's ability to obtain, understand and act on the health information, but the important part or the provider perspective is the provider's capacity to communicate clearly and educate about health, empowering patients to be able to understand the information.

So, both a patient and provider role to help make health information more understandable. Health literacy impacts all across the health care system. Health literacy impacts access, whether or not you can find the information, whether or not you know where to go, you hear about this a lot with folks accessing the emergency department, who maybe did not know where else to go. Other access issues related to that include safety, certainly safety issues related to medications and directions, and whether or not people understand them and can follow the directions particularly in an outpatient setting. Quality of care is impacted—whether folks are following up on their diabetes care in an outpatient setting, whether or not they have high satisfaction with their providers because they feel like they are being listened to and questions are being answered. Those pieces are put together under quality and certainly health literacy has an impact. Finally, there can be a significant impact on outcomes—understanding medication and treatment regimens, and overall general understanding of whether or not people can help manage and follow-up on those health instructions at least.

Health literacy is somewhat complex. It is more than just “can you read the information given to you?” To really think about being health literate involves reading, writing, arithmetic, being able to comprehend and advocate for oneself. It is difficult to be highly skilled and highly educated once you get into a health care setting where you are either ill or concerned about a loved one that is ill, trying to manage, understand, and apply all the information coming in your direction can be very difficult. I just want to take a minute to do a little activity with you to think about what it is like, to give you an opportunity to experience or remember what it feels like to struggle with reading information. Read the following paragraph on the next slide out loud together. You will have one minute to do this and I will even give you a hand, the words are written backwards.
So if everyone is ready we will read this paragraph backwards. Read it out loud together ideally. Ready? Go. Cleaning to assure high-performance --

Clean the tape heads?

About 30 seconds love.

Oh my. Whenever you notice an accumulation of dust and.

10 seconds left.

That's tough (laughter).

Make sure no [Indiscernible]

Time is that.

That's tough (laughter).

Did anyone finish?

No.

How did Bill?

-- how did it feel?

Not good.

That was horrible.

You think your patients ever feel like this when you give them the information?

Definitely.

Yes.

One thing to think about, sometimes you are so focused on figuring out what the word is, that you lose the context of the meaning. You might be able to actually read it but then to be able to step back and say, oh, that is actually what it said. Can anybody summarize what these instructions were poor? Did anybody get that far?

Cleaning a DVD or VCR him at the tape had? -- tape had?

That is the general gist of it. So, this is about your health care, this is the instructions you got sent home with. And 10 seconds after your provider gave it to you, he said “Do you have any questions? Would anyone know what to do?

No.
Certainly, hopefully, we are not giving information written backwards. But, the more that we can make information simple and easy to understand, the better. One of the early arguments in the whole health literacy movement was what about the people who are really well educated, would that insult them if I make this super simple? I think the findings are no, even folks who understand medical terminology, are well educated and highly health literate really appreciate simple instructions—simple information written in layman's language that anyone can follow. The whole health literacy movement focuses on making sure all the information you are providing is more health literate or reading level-appropriate, simple-to-read, with lots of white space and pictures when appropriate. Think about your discharge or after visit summary or discharge instructions as well as how you are having your discussions with teach back and thinking about how that works.

So, why this puts folks at risk if there's really a reliance on the written word for patient instruction. We know how much paper goes out with patient when they leave our institutions and we are really increasingly in a very complex healthcare system. Sometimes we hear from folks that people who are seen in the clinic or outpatient setting now used to be hospitalized on people in the hospital used to be in the intensive care, the complexity of care is continuing to get pushed down. More and more folks are in their homes taking care of themselves were maybe 20 years ago even 10 years ago that what -- that care would have been provided in a different format. So, I also think about self-care and a reliance for written word and reliance on things like the Internet, wealth people don't understand they can find on the Internet. Survey the Internet can be a very valuable tool for folks who are highly health literacy can be very challenging for folks who might not have either the Internet skills or literacy skills.

You need to find a page that has reparable information because there is all kinds of crazy things on the Internet. You need to be able to understand that, understand how it applies specifically to you, and actually a study that has shown for those at the lowest levels of literacy, 80% indicated that they never use the Internet to get health information. So, an assumption that people will find on the Internet is not always going to be the case.

When you think about health literacy and who is at most risk for complications or most at risk for being able to understand the health information you are providing, I am guessing this list of folks is probably looking familiar to you and might be the folks you're seen frequently in your hospitals, looking at providing that her information for the discharge process to you. The elderly, ethnic and racial minorities, those with limited education or immigrants a lot of times those always come together and sometimes you have liquid barriers the. Low socioeconomic status and oftentimes people with chronic illness.

Can we jump in here and add mental health?

Mental health. Yes.

Yes. So the link this is not re-hospitalization but the link to hospitalization. Patients with low literacy are nearly twice as likely to be hospitalized. As people with high literacy. It is not completely, solidly clear why this happens but perhaps folks don't understand. Their treatment regimen, make medication errors, present at later stages of illnesses or might use a emergency departments more often, lots of reasons that play into this. There have also been studies that indicate folks have trouble understanding discharge instructions. A Mayo study done, beginning to be a little old, done in 2005, did a study asking patients about their understanding after discharge and only 41% of patients discharged another study could accurately name their
diagnoses they had been in the hospital for. Less than 30% could name their medications back
closer to 40% could actually say what their medications did which is better than the amount who
could name them and only 14% knew the side effects of the medications. Do any of those
number surprise you?

No.

This is Neil at Fairview Range. One of the goals what this was to see the patient on the day after
admission so if we are saying ammonia or COPD patient am a baby by the second day they have
already got their new inhaler so, respiratory should have seen them for instructions on new
inhaler, pharmacy does a brief visit to save this is a new inhaler you are taking what it is for and
potential side effects so everything isn't done all it was a discharge. Now, hopefully we will see
them or maybe the nurse will see them on discharge and that has already been done they should
know what the inhalers for, given instructions on the inhaler now we are providing them with a
mid-list that take whatever the directions, two puffs twice a day, not everything at once so
hopefully that helps.

I think it is also multiple exposures.

Correct.

We need to hear things at least six times, six ways before we really can remember them.

And then nurse advocate, discharge advocate, hopefully follows the did you get all your
discharge meds, do you have your inhaler, how to use, that is part of the phone call.

Excellent. Good. Well, we are going to jump out of health literacy back to teaching and teach
back even though they are closely connected, but I am flipping back to the project RED slides
from the health literacy partnership, stuck a little bit about teaching and teach back. Ideally,
there will be multiple points during the phase, patient education be provided for the teach back
component would be great if all education material to be available at that time, that the care plan
is completed, two copies of the book and have them, you're able to meet in a quiet place, the
family or caregiver can be available if possible, I know one of the hospitals we worked with in
project RED started making appointments in air quotes, making appointments for patient
education the night before an anticipated discharge, mentioning that the family instead of the last
top there were all the paperwork and everybody is trying to get out the door, they anticipate the
discharge they were tried actually set a time the night before the evening before so the family
could be available, review the material and do that in a little bit less of a rush out of the little bit
more planned so that maybe one option for consideration if you're thinking about how this all fits
into that state and how it fits into folks workloads. When you ideally at that point with the teach
back you will review all parts of the patient care plan in using confirmed using a teach back
method.

We will talk a little bit about what those teach back methods are. Sometimes we have heard
stories about how you use that language. Teach back is really a terminology to describe
something, not something you might want to say to a patient. Teach back is a way to confirm that
you have explained a concept in a way that the patient needs to know and that they understand it.
Rather than a test of the patient, teach back evaluates how well you explained the concept. It
should be used with every patient--gain, never assuming literacy or health literacy.
Ideally all staff should know how to do it. Respiratory therapists, pharmacists, whoever is doing an education component with the patient. Are they able to do this teach back in a way that they are really assessing comprehension of the information?

When implementing teach back, the steps involve using simple, layperson language, explaining the concepts or demonstrating the process, and avoiding technical terms. If you have someone who may have a language barrier, use professional translators if possible. Ask the patient or caregiver to repeat the concept in his or her own words to demonstrate whatever process is used for an inhaler, for example. Identify and correct any misunderstandings. Ask them to repeat the concept or process to demonstrate understanding until you adequately understand what that process is. There are different ways to confirm that you have explained it appropriately.

Teach back: this is basically the same information in more of a graph about the clinician or whoever is providing education demonstrating the new concept, explaining the material, and assessing recall and comprehension. Ask the patient to either state back or demonstrate. Clarify if they do not understand it the first time. Another way to help explain: continue the circle until you have mass care comprehension. Although the pictures always make it look easy, we know this isn't quite that simple. We really encourage you not to ask patients “Do you understand?” because they will probably say, “Yes” whether or not they had any idea what the question was.

Ideally, don't ask yes or no questions. Asking patients to explain or demonstrate how they would do something and asking open-ended questions is a good way to get at this. I have a couple of examples of ways to frame this on the next line and -- next slide. Don't assume you haven’t provided adequate teaching if the patient doesn't explain correctly. It might be that what makes sense to you doesn't necessarily make sense to them. There might be a different way to describe how people practice something, a different word they use, how they use terminology or explain things when they are not talking to a health care provider or clinician.

Here are some common terminologies or ways to introduce the teach back concept if you are working with the patient.

For example, you could say “I want to be sure I did not leave anything out that I should've told you. Would you tell me what you were supposed to do so I can be sure you know what is important?”

Another example, “I want to make sure I did a good job explaining your medications, because it can be confusing. What changes did we decide to make and how will you now take the medication?”

Another way to frame this is to talk about what they would explain to someone else. “When you go home and your grandchild asks you what the doctor said about your heart, how are you going to explain this to your grandchild?” Or “How are you going to explain to your spouse how you will take these medications?”

Does anyone have any sort of active teach back training programs, or do you feel like it is been done, or is there an opportunity in your organization?

In Madelia, there is definitely opportunity.

All right. Can be done. Any? no.
I have some resources for you. How about Regions or Fairview Range?

At Regions, the mental health staff is using teach back. The nurses have all received education on it and so have the social workers.

Good. And how is it going?

Again, always opportunities for improvement.

Okay. I think it always sounds easier than it actually is. It sounds very basic. How about Fairview Range? Do we still have the Fairview Range folks?

Here at Range, all of our nurses have been educated on the teach back method.

Okay. Are you doing any documentation? Or, how is understanding confirmed.

We do document it. It is documented on our care plan currently.

In Madelia we record a document, discharge instructions were reviewed, patient verbalized understanding, but I think we need to do a little bit more work with nursing and that little project you have a student reading that paragraph backwards I think is a good place to start.

And Regions also documents the patient verbalized understanding. Also again with the advent of teach back encouraged to document the patient's level of understanding and discharge notes.

Another opportunity to take that teach back role out for examples might be to have some sort of shadowing set up. Not necessarily that a manager watches them do it and provides feedback, but a lot of times a colleague or someone you know who is really good at teach back. Is there a way on one of those days when you have only two patients instead of 15 you might be able to have folks shadow and observe—because it certainly is a skill. I think some people are going to do really well naturally and be much more comfortable. There is a need for ongoing feedback and review particularly by peers. I think when it comes to the manager, it can feel a little bit different. It is a nice way to help spread that learning among your staff.

So, sometimes there are people who might understand the instructions, but the question is whether or not they are actually going to follow their instructions. As I was preparing for this presentation, I was thinking about trying to get my first grade and fourth grade sons to clean the basement this weekend. They certainly understood the instructions. I even had them repeat them back to me, but whether or not they actually were going to follow through with them is a completely different question. This takes kind of a step beyond the teach back. Particularly Regions, this might follow close to your heart as you look at your mental health unit. Whether or not you think people are actually going to be able to follow the instructions, do you see yourself being able to follow them? Is there something that is going to keep you from following them, such as memory, lack of support, lack of trust, whether they think they need to do it, whether they can get medications, and whether they have transportation. Not only do you understand the instructions, but are you going to follow through? Has anybody had any experience with this next step of the discharge discussion? Or any best practices or e-learning? I want to make sure they understand that they are going to follow-through.
This is Regions. I know the social workers, as part of their discharge work talk about barriers to keeping appointments and to getting medications filled or refilled. We send patients out with medication but don't know if there are other questions around barriers or functional barriers.

Okay. It opens up another can of worms. Certainly there is often a lack of understanding on how to follow instructions. So how we start to tackle that is another session. Right now we're just going to share with you some of the teach back and health literacy resources. I pulled the slide on health literacy from the website right there, the Minnesota Health Literacy Partnership. If you want to do some training with your staff, they have two really nice resources available, the health literacy one on one and a module that has slides and talking points. That is what I actually pulled the slides from today. They also have a whole module on teach back, which includes a video with discussion questions you can share and sample agendas that help you layout the session if you have 15 minutes or 75 minutes for staff training. The more people are starting to study the issue, the more they recognize this needs to be something we do universally across our health care system versus tailoring it to patients we think might have low health literacy.

Questions on teach back or health literacy? We're going to jump into a couple of things here, before we leave that topic? Questions about? Okay. So we have our after visit summary, patient care plan altogether. We've done teach back, within the education there is post discharge activity that needs to happen as part of Project RED. Make sure the discharge summary and patient care plan is transmitted to the primary care provider. If it is by fax, was it received, is it legible? More and more of these things are pushed electronically. Is there some way to ensure it has actually been received? Certainly, we are in a different world from when people used to just send things through interoffice mail or fax without knowing whether it was received at the other end. Follow-up with a phone call to the patient in ideally 48 to 72 hours after discharge, or in the evening if they went home in the morning depending on what your resources are and how you can do that. On the Boston Medical site, the Project Red toolkit has a really nice script you can start with and adapt, including making a second call if warranted and what triggers might lead to that. I believe Fairview Range is doing some follow-up phone calls already. How's that working?

The patients we are calling with three diagnoses are identified on the care management team list and then the nurse in the group is typically making those calls or asking one of the supervisors or somebody else to make them. She is supposed to be in control of that list.

Okay. And other scripts they are using?

Yes.

What happens if somebody does have questions about their medications or -- what is the next step?

So far I have asked her and she has not really identified any real issues. But we have a shared document that have our calls and I think she is documenting in the shared folder so any of us can see what the patients need and the follow-up when were they are called.

Good. Does anyone else do follow-up phone calls?

This is Regions we call all patients who are discharged to home. There is a little bit of an issue with the electronic health record on what is defined as home; for example, if the patient is discharged to a ward as their home. But they are very mindful of patient privacy so if the patient
uses a shared answering machine or they can’t get directly to the patient they won't leave a message or leave a callback number. CMS is part of our problem and they define jail as home. So we don't call Jill patient -- Jill patient and we use a script as well.

Okay.

They try to call within 48 hours and make two attempts to reach the patient.

Okay. Pretty good process down there. Madelia? Have you been doing follow-up phone calls?

No. Not yet.

There are some nice scripts out there particularly on the Boston Medical website. So, if you are just starting or need time to take a step back and review scripts that's a nice resource for you. So, it felt like some of you are further than others but I think you should be starting to get a pretty good picture of how your redesigned discharge process will flow in your facility at this time. So, one of the next steps is to think about how you're going to teach and engage frontline staff in the process, particularly if you are piloting a specific unit. It is important to make sure people know what is going on around them and what changes might be made, as well as help in participation and understanding their roles. Ideally you will target nursing and medical staff, participating units, case managers, and whoever else might be touched with this.

Prior to the launch of an implementation, we again encourage you to pilot this. Start with areas you are piloting in and share the concepts and big picture--why you are doing this and what the plan for rollout at your facility is. So I know Fairview Range you've started to roll out some of this. What sort of teaching did you do with your frontline staff?

Actually, we talked about it in the unit meetings, on individual units, and with individual nurses throughout the rollout. So basically it was either group or one-on-one training.

Okay. And you feel like that went fairly well?

Actually, better than we anticipated.

Good.

Buy-in was pretty good.

I think a lot of times folks can see this as an opportunity for improvement. So they’re happy to see something is going to change. How about Regions? Have you trained frontline staff?

Yes and they have been working to improve the discharge process for probably over a year. Most recent changes have all been driven by the care model change they are working on. For the new mental health building we are moving into it the first part of December.

Okay.

So, again as part of our overall organization we do see the readmissions were they've always been denied for so I'll just nicely kind of rolled up together.
Okay so it kind of fits in with the bigger process changes as you are moving?

Right. The teach back in particular not just around discharge but around everything.

Right.

Yes.

This is Sam. A couple of weeks ago I managed to attend the IHI conference on readmissions. And regarding those who were on the flight, they were not too gung ho about having nursing staff doing transition coaching. Comments from the leaders presenting was that nurses or medical staff in general, tend to act on questions that people might have. They tend to take care of stuff instead of letting the patient understand what they need to do. So from their perspective, (IHI perspective) it should be nonmedical staff doing the transition coach or discharge process.

Coaches, particularly, are a really specific role in the care transition model. I can see that nurses are doers used to taking care of people. Are the coaches really helping folks figure out how to do it themselves? So what is the measure process for information you are collecting to know how this is going?

Here are some of the things that Project Red Module 3 suggests, a blog that the discharge advocate is using and when they were notified, the timeliness of the process, and also specific things about the patient care plan of checking back to make sure that information is being identified. Are you collecting any of these types of metrics? Or what other types of things are you tracking on to help understand how this is going in your organization?

This is Regions. We don't actually look -- all of our patients should go out with this. So it is all part of their discharge, after visit summary of the discharge plan which every patient we see -- receives. To look at is the going no -- to look at it specifically, no.

We developed a checklist for our frontline staff to complete and turn into nursing leadership. And at that point nursing leadership does complete the audit, the discharge summaries and discharge instructions that were sent with the patient.

Okay so what kinds of items were on the checklist?

It was broken down into each of our care areas, so social services, what we call our workloads, unit coordinators, and RNs. The discharge summary, lab results, anything to do with what we call logic care, are discharge instructions, follow-up appointment, and such.

Okay. Good. I think that after visit summary [Indiscernible] have this information in making sure it is out, regularly completed, is just to do a periodic check on those things. We have a section for follow-up appointments where they are actually being made. Or we have a section for pending testament of follow-up. So it is never a bad idea to check on those things on occasion because both are process pieces versus what was actually on the paper, the process to get the information in there did not actually happen. So good. Good. So, Module 3. The expected outcomes around the discharge order should be the discharge advocate is tracking on those pieces for the patient care plan. But there is the final teaching and teach back of the patient and family. In some cases it might be the discharge advocate and some cases there may be other stuff depending on how you roll that out. But that peace is a real key aspect of the discharge discussion and plan. There is
a follow-up with the transition summary in the patient care plan to the PCP. There are follow-up phone calls to the patient for some sort of measurement and tracking on how this is going to look at opportunities and again about how this is going to rollout more broadly with staff. So the module for checklist. The next step is to make sure the patient care plan after the discharge order, is finalized. Sounds like all of you are flux with how medical records and things begin. The teach back methods are outlined and staff trained, a couple of resources with the Minnesota Health Literacy Partnership in particular is a really nice module on teach back that can be done quite quickly with some video. Again this isn't somebody reading backwards. I've done a lot of health literacy training and that is always eye-opening for folks. Really helps to take a step back.

Making sure the staff understands what the project measurements are and are prepared to collect them. You never put a process in place without tracking things as you are moving along, including a process for transmitting the discharge summary for the PCP. Your process and follow-up phone call, script, are in place and your next tips for teaching your frontline staff. Now, it was our goal here today to actually have one of the other Project Red facilities share their experience. We found out late yesterday they will not be able to join us today so we will skip over the slide and that will give me more time to talk about how literacy, which is one of my favorite topics, will be in the next webinar. We plan to have an opportunity for you to hear from a couple of other facilities or at least one other facility on its Project Red experience.

Next we will do module December 3 from 12:00 to 1:30, focusing on planning and launching your pilot. Sounds like a couple of you are down that path. We hope to have at least one if not two other facilities share with you their lessons learned, and we will have an opportunity to talk about what barriers and challenges we may be running up against, joint thinking about that. Just a reminder of the websites, the joint commission resources, the Project Red blackboard we have access to for the project that has recorded versions of all of the modules as well as some other tools and examples that Project Red has put together. There is the link. Both the login and password are ARHQ. And the Boston University Medical Center who originally developed Project Red has recently updated controls. For example, I recently came across an updated script and permission on how to do the follow-up phone call. So that can be a nice resource for you as well. Questions? Or anything that we can provide that might be helpful for you guys? Things you think, “oh would be nice,” or “oh, I wonder if somebody has done X?”

This is Neil, I am curious with Regions working with behavioral site patients. We struggle on our site unit with these patients having a psych primary. Would you do with your discharge instructions you typically have a medical primary?

We do not as well. Our patients frequently don't have a primary and should. A lot of our patients have quite a few medical comorbidities that are aggravated due to their no-show rates on their appointments. It is a struggle sometimes to get them in to see a psychiatrist or any kind of follow-up. We have started the discharge clinic here at Regions on site, staffed by a behavioral health PA. They can see the patients for their initial interim appointment until we get them in someplace else. Through the County, again, there is a group process where the patient has to attend this intake group in order to be seen through Ramsey County. But for primary care it is a problem and so we have several providers on-site that are very good about writing discharge orders. The discharge information, most recent progress, patient structure, are all faxed forward to the next clinic. But not all of our providers are good about doing that.

Are your on-site clinics using medical and psych providers?
No. Mental health.

So, your discharge clinic, do you have hours every day? You encourage people to come back within a week? What is the protocol there?

We have hours every day. An appointment is made and they are encouraged to come back and they know how to get to Regions, so they come back. And we have quite a range here, 96 mental health beds, so we have quite a range of patients as well. We get some that are very high functioning that do have a primary care physician, and we certainly reach out to them when we can. And we have a fair number of homeless people as well. So we try and get to places like the Dorothy Day Center. We think our social workers are really very good. And we get case managers involved as well. It's a problem.

Not just a focus on the mental health population, but in general, they have also started doing some discharge clinics. They know people know how to get to the hospital, but they may not be willing to go to a primary care.

Right. And the med rec piece we were talking about earlier in the presentation, it is a challenge and a problem for all of our hospital population, not just the mental health population. When somebody can figure that out, boy, we will be in good shape.

Good.

Can I ask how many psych beds you have?

We have a 20 bed unit that is typically pretty full. One of the first meetings here, we did get a one-year MPM study with all patients in the mental health unit, specifically looking at metabolic syndrome interest by neuroleptic meds. Nearly all the patients had no medical primary. A lot of times they have mid-levels managing their psych meds, just the medical conditions get missed altogether, more of a struggle and they are discharged when they don't have a primary.

Right. As you know we are part of Health Partners, so we are part of this level integrated organization. We just found out about medication MPM appointments for our Health Partners injured patients. So we are slowly but surely rolling it out to the medical side.

That is where they actually have a benefit where they can do an MTM visit with the pharmacist?

Correct. Our MTM pharmacist will take other insurers as well, now. But also it becomes a problem for our uninsured population. Or underinsured.

Is that a separate appointment? Are people going to those? How does that work with no-shows.

It is. We just started it. It is a problem as you know to get patients there. It is not here at the hospital and 14 of our Health Partners clinics. Just rolled out to one of our medical units, one of our primary cardiac ineffective reverse. We haven’t obtained data yet on it. We know referrals are being made, case management, care management staff is taking ownership of that so we know they are reaching out and handing out flyers and it is all good. Just not a downside to that MTM visit I can honestly say.
We are using MTM to target the specific disease state CHF, COPD, and pneumonia if pharmacists will see them, if they our clinic referred them to MTM in the outpatient clinic.

You do both inpatient and outpatient?

Correct.

We are just starting outpatient so we only have a couple of outpatients.

Okay. We don't have the capability to do inpatient MTM. So we don't get paid for inpatient, more or less a pharmacy consult on the specific to-do discharge teaching and refer them for the outpatient.

Excellent. Madelia how was your pharmacy access? Do you have somebody who can help with some of those teachings and questions?

S. And we have involved her in probably the last month. Robin will be taking the next step, taking over the medication education part of it and med reconciliation for discharge.

Good. Good. Lots of good things going on. Really fun for me having stepped in and out of this to hear all the great work you guys have been doing. Please let us know if there are things you are looking for, things we can help with. We would appreciate you taking a minute to tell us how we can improve the experience for you. You will be getting an evaluation I believe that will be e-mailed out to you later today or tomorrow. Kim is still your primary contact. You can get a hold of her, or me as well, if you have questions. Kim is sort of the one heading the Project Red work at this point. Please let me know if there are questions. Without a hospital sharing with us today, we are going to end a few minutes ahead of time. So, thank you for spending the afternoon here with me today. I hope that you found this helpful, and look forward to hearing about the next steps on your Project Red journey.

Thank you for hosting.

Thank you.

[Event concluded]

If you have questions, please contact Stratis Health at info@stratishealth.org.

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