Discharge Information

Question Details

Discharge Instructions is considered an HCAHPS "summary measure" because it consists of two questions from the survey reported as one measure. By combining related questions into summary measures, similar questions are tied together. The Centers for Medicare & Medicaid Services reports that the statistical reliability of HCAHPS measures increases with the use of summaries. HCAHPS measurements of effective discharge planning are consumers' assessment of these specific components of hospital care:

- During this hospital stay, did doctors, nurses, or other hospital staff talk with you about whether you would have the help you needed when you left the hospital? (Q19)
- During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital? (Q20)

The scale for both questions is "Yes" or "No."

Overview

Healthcare reform has reduced the length of inpatient stays and at the same time, curbed the volume of readmissions, bringing a renewed energy to discharge planning and instruction. Discharge planning helps address the medical, psychosocial and community resource needs.

Discharge planning presents an opportunity is to design a patient and family-centric process, rather than re-engineering hospital-centered work processes. Many patients and their families end up being briefed on the discharge plan on their way out the door, with little opportunity to assimilate the information, ask questions, and have their questions answered. Even when the material is covered during a hospital stay, patients are sometimes foggy in recall, timid to ask questions, or too overwhelmed to manage care post-discharge.

Best Practices

Discharge Planning Begins at Pre-admission. The common wisdom of starting at the beginning is true with hospitals as well. The beginning is *prior* to a patient being admitted. Facilitate conversations with admitting physicians and their practice staff to help in providing education before a stay begins.
They called me one day before my surgery to tell me what medication I could and could not take before the surgery. I had already stopped taking aspirin but they should have called earlier than a day before my surgery.

Explain the Why. Often discharge instructions concentrate on what to do next. Include the reason for hospitalization and any key hospital-visit details. This helps the patient and family explain details to extended family and friends and augments their understanding.
The first nurse went out of her way to explain heart functions and even provided literature for me to read.

Teachable Moments. Great teaching moments take place throughout a patient's stay. Catch moments to show, teach and share with patients and families. Small snippets may cover details and overlap information, coming from multiple staff. They help reinforce the myriad of clinical information the patient needs to know in small doses, making it easier to grasp and remember.

Assessment Never Stops. As critical as an initial patient assessment is, ongoing assessment of the patient's condition and the patient/family's understanding, helps clinicians in meeting patient and family goals for education. This ongoing evaluation of the current state of a patient's understanding and willingness/ability to follow instructions at home helps clinical staff identify gaps along the way and match appropriate learning strategies to close those gaps.

Assess Knowledge, Skill and Attitude. Most needs assessments are designed to identify knowledge and skill gaps and customize education and discharge details to that gap. Fear, denial, apathy, or feelings of not being up to the task ahead serve as deterrents to effective post-hospital care as well. Identifying and addressing motivation and attitude issues will position patients for a better clinical outcome and bolster their confidence in managing their care. Silverton Hospital in Oregon developed "The Reality of Barriers," an activity and a barriers identification worksheet as part of their curriculum "Training Nurses to be Teachers." [1]

Standardize Discharge Forms and Instructions. Begin with high risk of readmission DRGS, such as heart failure patients, and have the forms designed by a multidisciplinary team from each department or division. If the team identifies key physician champions, tap into their expertise and enthusiasm to build support with medical staff.

Cover the Bases. Review your current home care instructions to see if the three Cs are covered. Is it patient-centered, concise, and comprehensive?

- Medication list, including dosage, times, frequency, and possible side effects
- Home care instructions such as activity level and types, diet, restrictions on bathing, wound care, as well as when the patient can return to work or school, or resume driving, etc.
- Signs of infection or worsening condition, such as pain, fever, bleeding, difficulty breathing, or vomiting
- Normal symptoms to expect once at home and length of time to expect them
- When to see the primary care physician for a follow-up appointment
- Post-discharge services such as home health and contact information

It has been a week since I got out of the hospital, and I just started bleeding again. I want to know if that is normal or not.

Teach Backs. In a nutshell, teach backs are simply asking questions of patients and families to require them to restate follow-up care instructions, using their own words. In doing so, clinicians elicit a patient/family's recall of post-discharge instructions. Teach backs are effectively an assessment of knowledge, a competency check for patients. Teach backs also help assess remaining knowledge retention gaps so that additional training is tailored to what the patient is still unable to recall.

Patient-Centered Discharge Instructions. Tailor your discharge instructions to the patient, taking into account health literacy and social circumstances when teaching the patient. Concentrate on high-value and high volume areas, such as medications and follow up for most common discharge plans. [2]
I had a connection with the physician-she talked to me as a peer and explained things at my level. There was a definite sense of communication between myself, my wife and her.
Listen, Write, Ask, Learn. When incorporating written discharge instructions in a patient's education, have the patient and family write on the materials, allowing them to translate the nurse's instructions into their terms and language. Encourage them to stop and ask questions, or catch up to what the nurse is saying. The final discharge instruction is a personal account by the patient and family of what should happen post-discharge.

Picture That. A complex wound and an anxious family gave birth to this best practice. Using the patient's cell phone, the nurse snapped a six picture process of the steps needed to change a dressing. First, she mapped out the steps, decided what supplies and action needed to be shown. Then, she scripted the pictured step and recorded it using the voice memo feature available on the patient's phone. HIPAA regulations were upheld ensuring the use of the patient's phone (with his approval), and obtaining the patient's written okay on the discharge paperwork. [3]

Discharge Planning Competencies. Annual competencies should include refreshers and audits, ensuring appropriate planning has occurred. Consider incorporating this aspect of clinical care in job descriptions and performance appraisals as well, linking clinical and service excellence to individual performance expectations.

HCAHPS Discharge Instructions Module. HealthStream's online learning trains staff to recognize the relationship between their everyday behaviors and actions and the patient experience of care. The module complements your organization's policies and ongoing education and provides an easy mechanism for managers to monitor full compliance in meeting cognitive competencies related to discharge.

Communication with PCP. While a person has been in the hospital, physicians other than the primary care physician have been in charge of the patient's care. Whether done

by telephone and/or in writing, information to be conveyed to the primary care physician includes:

- Overview of the hospital stay
- List of tests and surgeries performed, with results and a list of those still pending
- Summary of tests needed after discharge, such as a repeat chest x-ray
- Medication list the patient is being discharged with, including dosage and frequency
- Copy of the patient's discharge instructions
- When the patient should see the primary care physician for a follow-up appointment
- Plan for outpatient treatment, such as home intravenous antibiotics or parental nutrition to ensure that responsibility for this treatment has been clearly transferred and that the primary care physician accepts the treatment responsibility
- Name and contact information of hospitalists, intensivists and/or other providers responsible for the patient while hospitalized

Discharge Phone Calls. Ideally, discharge phone calls take place within forty-eight hours of discharge, but are still effective and appreciated when completed within a week, post-hospital stay. A personal call helps allay patients concerns about how well they are able to perform self-care instructions, provides a mechanism to review any test results after discharge, serves as a reminder of any follow-up appointments with their physician, and provides an opportunity to ask if the patient has any questions about medications, unexpected symptoms and the like. It is also a prime opportunity to provide a final act of service, checking that everything went well during the inpatient stay, offering amends if there was an issue, and offering well wishes and thanks to close the call.

Formalize and Document Callbacks. Set a threshold goal and stretch goal for contacting patients after their hospital stay. This not only serves as part of the record of the care for a patient, but adds accountability and measurement for this process goal. Some organizations use support call-back personnel in meeting patient and family needs that may arise, and train them on appropriate scope of service and channels for follow up, depending on the issue a patient shares.

Physician Documentation. While nurses, physical therapists, and other clinical staff carry out the majority of patient education, physicians also share the stage. Require physicians to document their ambulatory and office-based patient education practices related to post-acute care.

Fridge Reminders. People rarely remove refrigerator art. Send a fridge magnet home that includes a list of symptoms to watch for and an emergency number to call. Iowa Health System says the program helped the hospital cut unplanned-readmission rates in half, to 6%. Reference - St. Luke's Hospital, an Iowa Health System affiliate in Cedar Rapids, Iowa and IHI called Ideal Transition Home for Patients with Heart Failure

Transition Coach. A nurse or APP (Advanced practice practioner) is assigned to the patient from prior to admission to post-discharge. The clinician stays connected to the patient and follows up with discharge calls, and even home visits, coaching to help the patient gain mastery of self-care skills. [4]
There was a special nurse who was very helpful, particularly the last couple of days I was there. I had asked some questions, and she brought me a printout and took the time to explain everything I needed-it was very helpful to me.

"When Can I Leave?" Hospitals can do everything well and still leave a bad taste with a patient and family. Discharge can take several hours, or a day in some cases. Paint a realistic picture of when discharge will occur. Manage up the physician and the process while explaining the steps and protocol to discharge. Is your process too long? All the explanations in the world don't cover for a broken process. Is this an area ripe for a LEAN or other quality improvement initiative?

Schedule doctor office visits. Timely ambulatory follow up provides a seamless continuum of care, supporting the recovery or ongoing care issues. The problem is that sometimes a patient or family is so involved with discharge and getting settled at home that they forget to call the clinic or schedule additional testing, etc. as part their post-hospital care instructions.

Arrange Transportation. Patients are often willing to see their physician and can remember the event, but lack a way to make their visit. Some cities offer door-to-door public transportation gratis or for a minimal cost.

Learning Modules

- **HealthStream's HCAHPS Module 9: Discharge Information Training Module**

To view courses in the HealthStream catalog that correspond to our Best Practices, please go to http://catalog.healthstream.com. On our catalog you can search by course title, subject area or by HealthStream's courseware partners. To view a demo of a course please register and then click the "View Demo" link. Available courses are subject to change.

References and Resources

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