



How-to Guide:

Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations

Support for the How-to Guide was provided by a grant from The Commonwealth Fund.

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How to cite this document:

Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. *How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2012. Available at www.IHI.org.

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Acknowledgements

The Commonwealth Fund is a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff.

The Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization that works with health care providers and leaders throughout the world to achieve safe and effective health care. IHI focuses on motivating and building the will for change, identifying and testing new models of care in partnership with both patients and health care professionals, and ensuring the broadest possible adoption of best practices and effective innovations. Founded in 1991 and based in Cambridge, Massachusetts, IHI mobilizes teams, organizations, and increasingly nations, through its staff of more than 100 people and partnerships with hundreds of faculty around the world.

The Robert Wood Johnson Foundation provided support for developing this document through Transforming Care at the Bedside (TCAB), a national program of the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement. The TCAB initiative launched in 2003 and the *TCAB How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure* was first made available in October 2007.

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I. Introduction

Delivering high-quality, patient-centered health care requires crucial contributions from many parts of the care continuum, including the effective coordination of transitions between providers and care settings. Poor coordination of care across settings too often results in rehospitalizations, many of which are avoidable. Importantly, working to reduce avoidable rehospitalizations is one tangible step toward achieving broader delivery system transformation.

The Institute for Healthcare Improvement (IHI) has a substantial track record of working with clinicians and staff in clinical settings and health care systems to improve transitions in care after patients are discharged from the hospital and to reduce avoidable rehospitalizations. IHI gained much of its initial expertise by leading an ambitious system-redesign initiative called [Transforming Care at the Bedside \(TCAB\)](#). Funded by the Robert Wood Johnson Foundation, TCAB enabled IHI to work initially with a few high-performing hospital teams to create, test, and implement changes that dramatically improved teamwork and care processes in medical/surgical units. One of the most promising TCAB innovations was improving discharge processes for patients with heart failure (see the [TCAB How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure](#) for a summary of the “vital few” promising changes to improve transitions in care after discharge from the hospital and additional guidance for front-line teams to reliably implement these changes).

In 2009, IHI began a strategic partnership with the American College of Cardiology to launch the [Hospital to Home \(H2H\) initiative](#). The goal is to reduce all-cause readmission rates among patients discharged with heart failure or acute myocardial infarction by 20 percent by December 2012. H2H leverages an array of national initiatives intended to reduce readmissions and catalyze action to improve patients’ care transitions.

IHI is also leading a groundbreaking multistate, multistakeholder initiative called [STate Action on Avoidable Rehospitalizations \(STAAR\)](#). The aim is to dramatically reduce rehospitalization rates in states or regions by simultaneously supporting quality improvement efforts at the front lines of care while working in parallel with state leaders to initiate systemic reforms to overcome barriers to improvement. Since 2009, STAAR's work in Massachusetts, Michigan, and Washington has been funded through a generous grant provided by The Commonwealth Fund, a private foundation supporting independent research on health policy reform and a high-performance health system.

The Case for Creating an Ideal Transition Home and Reducing Avoidable Rehospitalizations

Hospitalizations account for nearly one-third of the total \$2 trillion spent on health care in the United States.^{1,2} In the majority of cases, hospitalization is necessary and appropriate. However, experts estimate that 20 percent of US hospitalizations are rehospitalizations within 30 days of discharge.^{1,2} According to an analysis conducted by the Medicare Payment Advisory Committee (MedPAC), up to 76 percent of rehospitalizations occurring within 30 days in the Medicare population are potentially avoidable.³ Avoidable hospitalizations and rehospitalizations are frequent, potentially harmful and expensive, and represent a significant area of waste and inefficiency in the current delivery system.

Poorly executed care transitions negatively affect patients' health, well-being, and family resources and unnecessarily increase health care system costs. Continuity in patients' medical care is especially critical following a hospital discharge. For older patients with multiple chronic conditions, this "handoff" takes on even greater importance. Research shows that one-quarter to one-third of these patients return to the hospital due to complications that could have been prevented.⁴ Unplanned rehospitalizations may signal a failure in hospital discharge processes, patients' ability to manage self-care, and the quality of care in the next community setting (office practices, home health care agency, and skilled nursing facilities).

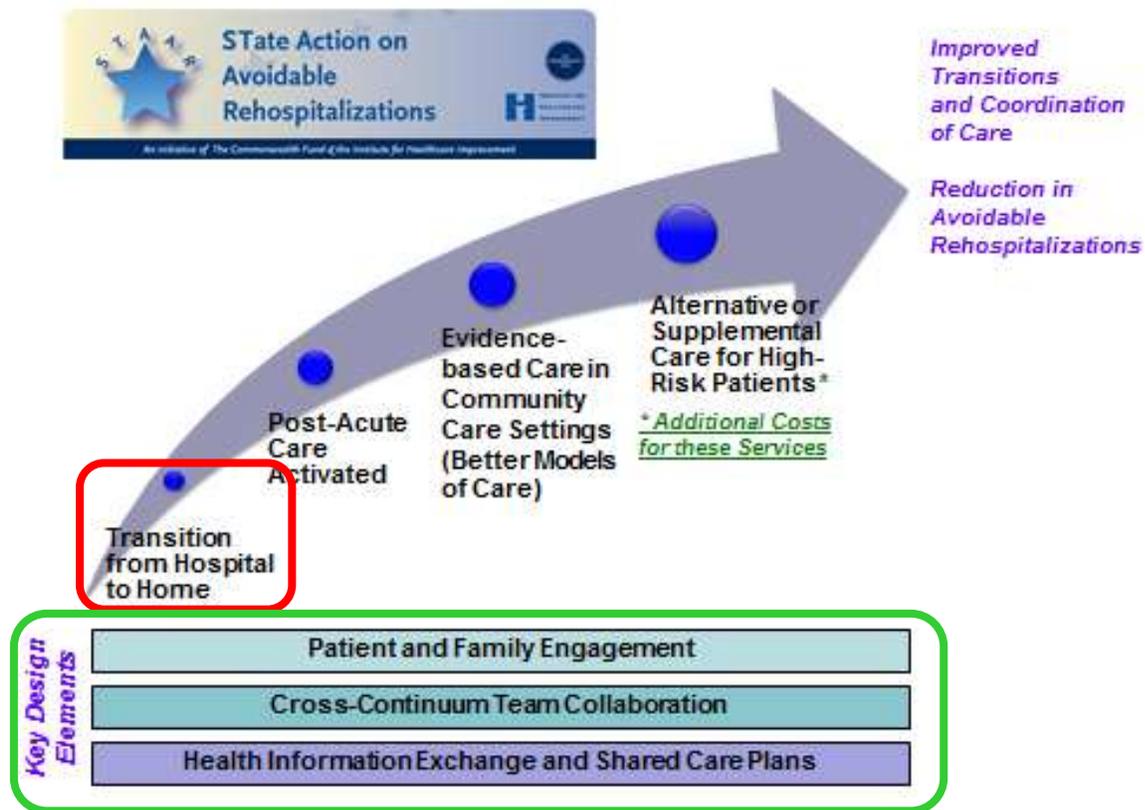
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This How-to Guide is designed to support hospital-based teams and their community partners in co-designing and reliably implementing improved care processes to ensure that patients who have been discharged from the hospital have an ideal transition home or to the next community care setting.

Based on the growing body of evidence and IHI's experience to date in improving transitions in care after a hospitalization and reducing avoidable rehospitalizations, IHI has developed a conceptual framework or roadmap (Figure 1) that depicts the cumulative effect of key interventions to improve the care of patients throughout the 30 days after patients are discharged from a hospital or post-acute skilled nursing facility.

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Figure 1: IHI's Roadmap for Improving Transitions in Care after Hospitalization and Reducing
 Avoidable Rehospitalizations

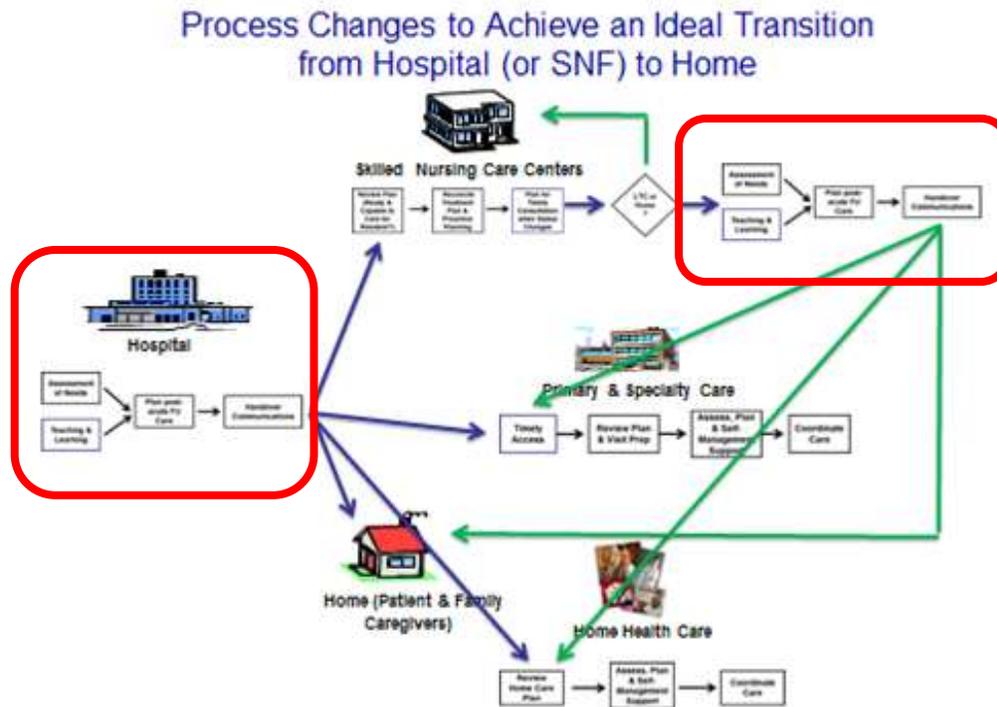


The transition from the hospital to post-acute care settings, which is depicted in the red box in Figure 1, has emerged as an important priority in IHI's work to reduce avoidable rehospitalizations and it is a major focus of this How-to Guide. Guidance for leveraging the key design elements to improve care transitions (depicted in the green box in Figure 1) is also included in this How-to Guide.

Transitions in care after hospitalization involve both an improved transition out of the hospital (and from post-acute care and rehabilitation facilities) as well as an activated and reliable reception into the next setting of care such as a primary care practice, home health care agency, or a skilled nursing facility. These transitions in care after a hospitalization are depicted in Figure 2. An example of an activated receiver is a physician's office with a specified process for scheduling post-hospital follow-up visits within 2 to 4 days of discharge. "Although the care that prevents rehospitalization occurs largely outside of the hospital, it starts in the hospital."⁵

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Figure 2: Process Changes to Achieve an Ideal Transition from the Hospital (or SNF) to Home



The processes to improve care transitions from hospitals or SNFs to home from are highlighted by the red boxes in Figure 2. IHI provides additional How-to Guides for the other process changes and improvements recommended for clinical office practices, skilled nursing facilities, and home health care agencies. These How-to Guides are designed to assist clinicians and staff in office practices, skilled nursing facilities, and home health care agencies in developing processes that ensure a timely and reliable transition into each of the community care settings.

- [How-to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations](#)
- [How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations](#)
- [How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations](#)

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Section V of this How-to Guide also includes guidance on a recommended infrastructure and strategies for achieving results. Case studies in Section VI give detailed descriptions of how two different organizations implemented successful strategies to reliably implement the changes recommended in this How-to Guide to achieve results in reducing avoidable readmissions.

II. Key Changes

This How-to Guide outlines four recommended changes for improving the transition from the hospital (or SNF) to home or to a community care setting, with the goal of reducing avoidable hospital readmissions (Figure 3).

Figure 3: Key Changes to Improve the Transition to Home or to a Community Care Setting

<p>1. Perform an Enhanced Assessment of Post-Hospital Needs</p> <ul style="list-style-type: none">A. Involve the patient, family caregiver(s), and community provider(s) as full partners in completing a needs assessment of the patient's home-going needs.B. Reconcile medications upon admission.C. Create a customized discharge plan based on the assessment.
<p>2. Provide Effective Teaching and Facilitate Enhanced Learning</p> <ul style="list-style-type: none">A. Involve all learners in patient education.B. 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.
<p>3. Ensure Post-Hospital Care Follow-up</p> <ul style="list-style-type: none">A. Assess the patient's medical and social risk for readmission and finalize the customized discharge plan.B. Prior to discharge, schedule timely follow-up care and initiate clinical and social services as indicated from the assessment of post-hospital needs and the capabilities of patients and family caregivers.
<p>4. Provide Real-Time Handover Communications</p> <ul style="list-style-type: none">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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Note: There is significant alignment regarding these four recommended process improvements among other key research and improvement initiatives (BOOST,⁶ RED,⁷ and H2H⁸) that aim to improve the discharge processes in hospitals.

1. Perform an Enhanced Assessment of Post-Hospital Needs

Recommended Changes:

1A. Involve the patient, family caregiver(s), and community provider(s) as full partners in completing a needs assessment of the patient's home-going needs.

1B. Reconcile medications upon admission.

1C. Create a customized discharge plan based on the assessment.

Before beginning this improvement work, most teams believe that they are already performing enhanced assessments on admission. However, after completing the Diagnostic Review, team members gain new insights into what they are missing. Clinicians should ask themselves,

“How can we gain a deeper understanding of the comprehensive post-discharge needs of the patient through an ongoing dialogue with the patient, family caregivers, and community providers?”

An initial assessment should be completed upon admission, but ongoing assessment of home-going needs should occur throughout hospitalization.

Typical failures in the assessment of discharge needs include the following:

- Excluding the patient and family caregivers in assessing needs, identifying resources, and planning for discharge, leading to poor understanding of the patient's capacity to function in the home environment;
- Lack of probing around unrealistic patient and family optimism to manage at home;
- Lack of understanding of the patient's functional ability, physical and cognitive health status, and social and financial concerns, which results in transfer to a care setting that does not meet the patient's needs;
- Not addressing the whole patient (e.g., focusing on one condition, missing underlying depression, social needs, etc.);
- Not addressing palliative care or end-of-life issues, including advance directives or planning beyond Do Not Resuscitate (DNR) status;

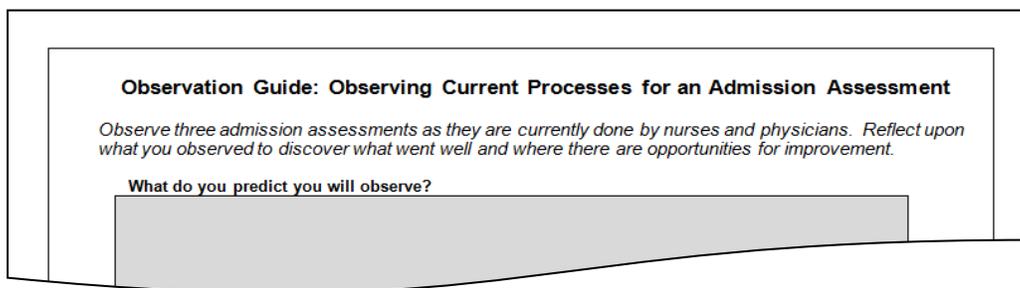
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- Medication errors, polypharmacy, and incomplete medication reconciliation; and
- Labeling the patient as noncompliant and not recognizing the care team’s responsibility for facilitating self-care management.

What are your typical failures and opportunities for improvement?

- Review the findings from the Diagnostic Review (Step 3 in Section IV. Infrastructure and Strategy to Achieve Results) with front-line improvement team(s) on pilot unit(s). Periodically repeat the Diagnostic Review to continually learn about opportunities for improvement.
- Use the Observation Guide: Observing Current Processes for an Admission Assessment (Figure 4) to learn about opportunities to improve the admission assessment

Figure 4: [Observation Guide: Observing Current Processes for an Admission Assessment](#)
(How-to Guide Resources, page 94)



Recommended Changes

1A. Involve the patient, family caregiver(s), and community provider(s) as full partners in completing a needs assessment of the patient’s home-going needs.

“Family caregivers” is the phrase used in this How-to Guide to represent those individuals who are directly involved in care of the patient at home or at other community care settings. Visitors to the hospital are not necessarily the persons who best understand the home environment limitations, issues of transferring to another care setting, or who will help the patient with self-care at home.^{9,10} “Community providers” are all of the clinicians and staff (e.g., home health care and palliative care nurses; primary care providers and specialists; skilled nursing facility staff; staff in elder and mental health services or community agencies) who have a role in the care of the patient when they are at home or in a skilled nursing facility.

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The post-hospital needs assessment should include the following:

- Cognitive and functional capabilities and needs;
- Ability to perform self-care and monitor health status at home or in the community setting as needed (e.g., weight, symptom log, and blood sugar monitoring); in other words, the patient and/or identified family caregiver(s) are able to show that they understand what they need to do to care for the patient at home;
- The care capacity of the home environment, including whether there is a willing, available, physically and mentally competent family caregiver(s) where and when needed;
- Sources of primary care, specialty care, and home health care;
- Access to social and financial resources; and
- Community supports, such as Meals on Wheels.

The involvement of patients and family caregivers is an essential step in assessing the post-discharge needs of patients. In the admission assessment, during bedside change of shift reports and in ongoing conversations with patients and family caregivers, clinicians should utilize open-ended statements or questions to discover contributing causes for unplanned admissions or readmissions and worries about going home. Whiteboards in the patients' rooms can be utilized to facilitate these conversations among the care team, patients, and family caregivers (see Figure 5). This information about the home-going needs of patients should be brought to the daily multidisciplinary care rounds. Asking the following questions of patients and family caregivers will help to assess the comprehensive home-going needs of patients:

- *How do you think you became sick enough to come back to the hospital?*
- *Have you had any problems taking your medications?*
- *Describe your typical meals at home.*
- *Did you see your doctor or another clinician in the office before you came back to the hospital?*
- *What are you worried about when going home or to a skilled nursing facility?*

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accurate medication list as well as information on the patient's history of filling and following medication regimens.

- Many hospital-based teams are collaborating with staff in skilled nursing facilities to standardize the use of these communication tools to facilitate transfers to and from the community-based care facilities. INTERACT is a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities. The goal of INTERACT is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital. The tools are available on the INTERACT website (www.interact2.net/).

1B. Reconcile medications upon admission.

An accurate medication use history and reconciliation with admission orders on admission to the hospital is an important component of safe patient care both during the hospital stay and at transition from the hospital to community settings.

- When taking the patient's medication history, involve the patient, family caregivers, the clinical care provider and/or primary care physician, and, if possible, pharmacists from the patient's local pharmacy, to ensure the history is complete and accurate on admission.
- If the patient has had home health care services, contact the home health care agency for a list of current medications; often agency staff have been in the home and have the most up-to-date and accurate list.
- All medications should be reconciled on admission by a suitably trained professional and a record of the reconciliation should be part of the medical record.^{11,12} The correct list at admission is crucial to the subsequent success with medication reconciliation.

1C. Create a customized discharge plan based on the assessment.

A customized and structured discharge plan based on patient needs "reduces readmission rates for older people admitted to the hospital with a medical condition."¹³ The person designated to be accountable for the effective discharge of the patient (e.g., the patient's primary nurse, a

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case manager, a discharge planner, a discharge coach, or a hospitalist) should initiate the patient's plan of care based on the enhanced assessment.¹⁴

Suggestions for creating a customized discharge plan are listed below.

- Expand the focus of daily discharge rounds to multidisciplinary rounds, for which there is a dual focus on optimizing the hospital care and discharging the patient, and a focus on initiating the post-acute care plan with the aim of reducing avoidable readmissions.
- To facilitate communications among the care team, the patient and family caregivers use the whiteboard in the patient's room to communicate: the daily goals for the hospital care, the expected discharge date, the post-hospital care plan, and patient and family caregiver questions, concerns, and worries. (See examples of whiteboards in Figures 5a, 5b and 6). If multidisciplinary rounds do not occur at the bedside, this information should be regularly communicated to the multidisciplinary care team at daily rounds.
- All members of the care team should contribute information about the each patient's post-discharge needs and these needs should ideally be summarized into one centralized care plan to be used in multidisciplinary rounds.
- Be proactive in initiating advanced illness planning and palliative care referrals for patients who have had numerous rehospitalizations. If you do not currently have a palliative care program in your hospital, the Center to Advance Palliative Care website contains a wealth of resources and information (www.capc.org).
- As the patient approaches the discharge date, the multidisciplinary care team should ask the question – ***Do we think this patient is likely to be readmitted in the next 30 days? If so, why?*** If the care team assesses that the patient is likely to be readmitted, what plans can be initiated to better support the patient at home or in the next setting of care?
- Communicate as early as possible with agencies if referrals for home health care, skilled nursing facilities, care managers, or a transitions coach or APN are under consideration.^{4,39}

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Figure 6: Example of Discharge Planning at the Patient's Bedside
Virginia Mason Medical Center, Seattle, WA

The image shows a 'TICKET HOME' form. The title 'TICKET HOME' is at the top left. To the right, there are fields for 'Date', 'MRN', and 'Patient's Schedule / Procedure / Diagnosis'. Below the title, there are fields for 'Projected Discharge Date' and 'Time'. The 'Patient Milestones' section includes checkboxes for: 'I can feed myself', 'I can toilet myself', 'I can walk safely', 'My pain is controlled on oral meds', and 'Medical Goals Met (Data, etc.)'. The 'DC GOALS / NEEDS' section includes checkboxes for: 'I can walk safely around my home', 'Safety Risks addressed', 'Learning Needs Met', and 'Ride Home Arranged / Time'. At the bottom, there is a note: 'If you have any questions or concerns, please ask your care team.'

www.ihl.org/knowledge/Pages/ImprovementStories/ShesGotaTicketToGoHome.aspx

Provide a way for patients and family caregiver(s) to keep track of the key things they need to know as the patient transitions home — for example, the “Going Home” form (Figure 7). Care team members should assist patients and family caregiver(s) in completing the form.

Figure 7: [Going Home: What You Need to Know](#) (How-to Guide Resources, page 96)



Available at www.nextstepincare.org/left_top_menu/Caregiver_Home/.

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For more information on creating a customized discharge plan, please refer to the following resources:

Centers for Medicare & Medicaid Services *Your Discharge Planning Checklist*. Available at www.medicare.gov/publications/pubs/pdf/11376.pdf.

Project BOOST *Tool for Addressing Risk: A Geriatric Evaluation for Transitions..* Available at www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/PDFs/TARGET.pdf.

For Patients: *Leaving the Hospital and Going Where?* United Hospital Fund Next Step in Care Campaign. Available at www.nextstepincare.org/left_top_menu/Caregiver_Home/Leaving_the_Hospital?tr=y&aid=8100367&tr=y&aid=8251293.

For Providers: *Hospital Discharge Planning – First Steps with Family Caregivers*. United Hospital Fund Next Step in Care Campaign. Available at www.nextstepincare.org/uploads/File/Guides/Provider/Provider_Hospital_Discharge_Planning.pdf?tr=y&aid=8100387&tr=y&aid=8251301.

Recommended Process Measures for Performing an Enhanced Assessment of Post-Hospital Needs (How-to Guide, page 86)

Use the recommended process measures below to determine how reliably patients and family caregivers and community providers are included in assessing post-discharge needs.

- Percent of admissions where patients and family caregivers are included in assessing post-discharge needs.
- Percent of admissions where community providers (e.g., home health care providers, primary care providers, and nurses and staff in skilled nursing facilities) are included in assessing post-discharge needs.

2. Provide Effective Teaching and Facilitate Enhanced Learning

Recommended Changes:

2A. Involve all learners in patient education.

2B. 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.

The 2007 MedPAC Report notes that patient adherence with discharge instructions affects the rate of rehospitalization.¹⁵ However, the ability of patients to follow instructions provided at discharge is hindered by the complexities of medical issues, jargon used in the health care setting, and the stress associated with hospitalization.¹⁶ Literacy is a stronger predictor of health status than age, income, employment status, educational level, or racial or ethnic group.¹⁷ The problem is universal; all patients may struggle with comprehension in the stressful circumstances surrounding health care activities, worries, and distractions.

“How can we gain a deeper understanding of patient and family caregiver understanding and comprehension of the clinical condition and self-care needs after discharge?”

Effectively teaching all patients about their conditions, medications, and care processes requires careful design and use of patient teaching and written materials to enhance understanding of what is taught. Cross-continuum teams should strongly consider redesigning printed teaching materials for patient and family caregivers for use in all clinical settings. These materials should include necessary (not nice-to-know) content, simple layout and design, clear illustrations and appropriate reading level. Partner with patients and family caregivers to test and revise these materials. Use these two universal principles for health literacy in developing these written materials.

Reader-friendly written materials: Simple words (one to two syllables), font size 14 point, short sentences (four to six words), short paragraphs (two to three sentences), no medical jargon, consistent language, two-word explanations (e.g., water pill or blood pressure pill), remove ranges, and use abundant white space and pictures or visual aids.¹⁸

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Content redesign: Focus on what the patient needs to know, delivered in easy-to-understand formats.

For more information on redesigning patient teaching print materials, please refer to the following resources:

- *Simplified Heart Failure Patient Teaching Materials*. University of North Carolina at Chapel Hill. Available at www.nchealthliteracy.org/communication.html. The patient-friendly teaching materials, *Heart Failure Self-Management – Caring for Your Heart: Living Well with Heart Failure*, include detailed images and clear, low-health-literacy appropriate language.
- *Easy-to-Read Written Materials*. US Health Resources and Services Administration. Available at www.hrsa.gov/healthliteracy. The health literacy section of the website contains free and easy-to-read health brochures and information in various languages.

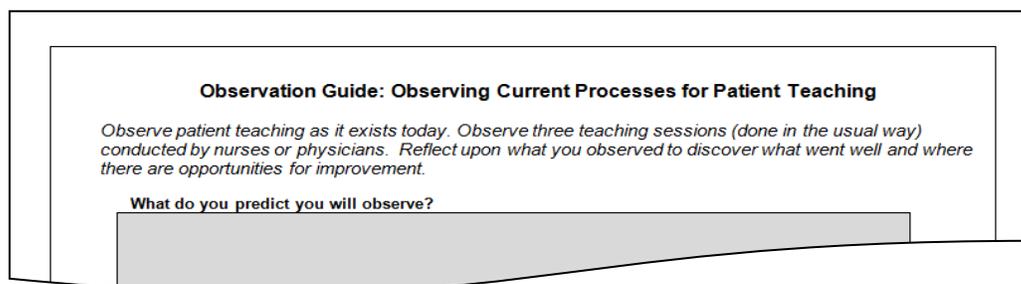
Typical failures found in patient and family caregiver education include the following:

- Assuming that the patient is the key learner;
- Providing written discharge instructions that are confusing, contradictory to other instructions, or not tailored to a patient’s level of health literacy or current health status;
- Failure to ask clarifying questions about instructions and plan of care: and non-adherence of patients regarding self-care, diet, medications, therapies, daily weights, follow-up, and testing, due to patient and family caregiver confusion.

What are your typical failures and opportunities for improvement?

- Evaluate through observation the effectiveness of the current discharge teaching process for patient understanding of self-care. Use the Observation Guide: Observing Current Processes for Patient Teaching (Figure 8).

Figure 8: [Observation Guide: Observing Current Processes for Patient Teaching](#) (How-to Guide Resources, page 99)



Recommended Changes

2A. Involve all learners in patient education.

Patients, family caregiver(s), and other care providers should actively participate in learning about the patient's care plan at home or in the next setting of care. Suggestions for identifying and engaging family caregivers and others who will be helping with their care after discharge from the hospital are included here.

- Visitors to the hospital are not necessarily the persons who best understand the home environment limitations, issues of transferring to another care setting, or who will help the patient with self-care at home.^{9,10} The following questions are useful in discovering critical information and who the key learners may be:

Who lives with you?

Who helps you with your medications?

Who makes your doctor's appointment?

How will you get to your doctor's appointment?

Who prepares your meals; who cooks?

Who does the housework?

Who does the grocery shopping?

Who else do you want involved in your care?

- Identify who should be present when doing teaching. Noting the key learner(s) in the patient's chart or electronic health record, and the plan of care on the whiteboard in the patient's room, have proven helpful. Patient and family permission to post information in the room is needed.
- Engage all learners and use Teach Back in teaching about post-discharge plans and instructions about home care.

2B. Use Teach Back and health literacy principles regularly throughout the hospital stay to assess the patient's and family caregivers' understanding of discharge instructions and ability to perform self-care.

Patients experience several challenges with learning about their participation in their own care after leaving the hospital. Patients are often very sick and struggling to understand in a busy environment of unfamiliar language, processes, and concepts. In growing numbers, hospitalized

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patients are older and suffer multiple chronic conditions and have more complex treatments requiring numerous medications, self-care activities, and the help of other individuals and caregivers. Patient teaching has become dependent on historical methods with too little consideration for what the patient can absorb at the time. The paradigm needs to shift from focusing on what clinicians are teaching patients to focusing on what patients and their family caregivers are learning.

Guidelines for WHAT to teach:

- Use Ask Me 3™, which outlines three simple but essential questions that patients should ask their providers to formulate patient teaching: 1) What’s my main problem? 2) What should I do for that problem? and 3) Why is that important? Ask Me 3™ also encourages patients to advocate to get this information about their care, and reinforces with providers the need to maximize patient and family understanding.¹⁹
- During the acute care hospitalization only essential education is recommended.²⁰ Focus on key need-to-know points, only what is vital (not nice-to-know).
- Emphasize what the patient should do, what action to take.
- The tool depicted in Figure 9 below provides key educational topics for patients with Heart Failure, COPD, Stroke, Chronic Kidney Disease, and Mental Health diagnoses.

Figure 9: [Key Educational Topics for High-Volume Clinical Conditions](#) (How-to Guide Resources, page 101)

Key Educational Topics for High Volume Clinical Conditions St Luke’s Hospital, Cedar Rapids, Iowa, 2011					
Pick an educational topic to teach your patient/family. Narrow it down to four or more teaching points: the “must haves” or “vital few” for the patient/family to know when discharged.					
Generic	Heart Failure	COPD	Stroke	Chronic Kidney Disease	Mental Health
<p>Patient should explain diagnosis and health problems for which they need care.</p> <p>General understanding of disease process and self care. Identify reason for hospitalization and</p>	<p>How would you explain heart failure to your family?</p>	<p>Tell me what you know about your COPD.</p>	<p>Do you know what happens when you have a stroke?</p>	<p>What do you need to do every day when you get home?</p> <ul style="list-style-type: none"> • Monitor B/P • Weigh daily – in the 	<p>Tell me how you would describe your condition to someone.</p>

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Guidelines for HOW to teach:

- Ask patients and family caregiver(s) how they learn best. Provide as many educational resource alternatives as possible, including written material, videos, audio recordings, face-to-face discussions, and interpretive services.²¹
- Slow down when speaking to the patient and family, and break messages into short statements. Use easy-to-learn segments of critical information to help patients and family caregivers master the learning more easily.
- Use plain language and eliminate medical jargon. Ensure verbal words and written words match.
- If written materials are used, highlight or circle key information.
- Avoid duplication of paperwork in materials patients take home.
- Provide office practices and skilled nursing facilities with a copy of the patient education packet. Use the same material, if possible, or build on each others' content.

Using Teach Back to Assess Patient and Family Caregiver Understanding

Teach Back involves asking the patient or family caregiver to recall and restate in their own words what they thought they heard during education or other instructions. According to the published literature, the practice of asking patients to recall and restate what they have been told is one of the eleven top patient safety practices.²² “Return demonstration” or “show back” is also a form of “closing the loop” where the patient is asked to demonstrate to the clinician how he or she will do what was taught. This technique is used routinely in diabetic education and physical therapy. Use Teach Back to assess the patient’s and key learners’ ability and confidence to perform self-care, take medications, or access help and close the gaps in understanding.^{20,23}

- Explain needed information to all key learners (the patient and family caregivers).
- Stop and check for understanding using Teach Back: Ask in a non-shaming way for the individual to explain in his or her own words what was understood. For example, *“I want to make sure I explained everything to you clearly. Could you explain to me in your own words...?”*

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- Check for understanding by the patient after each segment or portion of the information. For example, after telling the patient how to take his/her “water pill” and again after explaining the reasons to call the doctor.
- Patients and caregivers should not feel Teach Back is a test. The emphasis is on how well you explain the concepts, placing the responsibility on the teacher not the learner.
- If a gap in understanding is identified, offer additional teaching or explanation followed by a second request for the patient to explain back in their own words. Emphasize what they must do when they get home.
- Use multiple opportunities while the patient is in the hospital for review of important information to increase patient and family caregiver recall and confidence.
- If the patient and/or family caregiver cannot Teach Back, inform the care providers in the next care setting and adjust the transition plan accordingly.

Use Teach Back or return demonstration to assess the patient’s (or family caregiver’s) ability to fill prescriptions and adhere to medications. Non-adherence to a medication regimen may be driven by literacy skills, ineffective teaching, and lack of resources to purchase medications and secure transportation.²⁴ Consider using a standardized template to prompt nurses and other clinicians to document the patient’s understanding of what was taught, for example, a formatted Teach Back note in the patient’s chart (Figure 10).

Figure 10: Baystate Medical Center Teach Back Note

Teach-Back Note

Nursing Identifies: Primary Learner _____
Primary Language _____
Please enter above information in CIS, via RN to RN communication.

Patient education on importance of :

2,000 mg or less NA restriction daily (500 mg a meal x3 meals, 250mg a snack x2 snacks daily; give restriction form) with _____% teach back

Reading labels with patient (give pre-printed nutrition labels)

**** Explain hidden salt, + 5 different types of salt (give patient info on "Why salt is harmful to patients with HF" and teach no salt shaker with _____% teach back.

1500 cc Fluid Restriction daily (which is equal to 48 oz daily or (6)8ozcups) (give pre-printed restriction form) with _____% teach back.

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Many hospital teams have spread Teach Back competencies to all nursing staff and built this into yearly competency validation process. Teach Back must be practiced and role playing Teach Back is an excellent learning opportunity.

Figure 11: Example of a Program to Assess Nurses' Teach Back Competencies

St Luke's Hospital, Cedar Rapids, Iowa Nursing Competency Assessment for Teach Back

Annual Teach Back Competency Validation Day

- o Methodology
 - The learning station will use discussion, role playing and patient teaching scenarios to help RNs communicate effectively with patients and family members.
- o Each individual will participate in a role-play providing education to a patient. The following will be assessed:
 - Ability to do teach back in a shame-free way, e.g. tone is positive
 - Utilization of plain language for explanations
 - Whether individuals ask -- "Do you understand?"

ST. LUKE'S
HOSPITAL
IOWA HEALTH SYSTEM

A full description of this [Teach Back Competency Assessment Program](#) can be found on page 103 in the Resources Section.

[Recommended Process Measures](#) (How-to Guide Resources, page 86)

Use these measures to determine the effectiveness of Teach Back training processes:

- Percent of observations of nurses teaching patient or other identified learner where Teach Back is used to assess understanding.
- Percent of patients who can Teach Back 75 percent or more of what they are taught when content is broken into easy-to-learn segments.

3. Ensure Post-Hospital Care Follow-Up

Recommended Changes:

3A. Assess the patient's medical and social risk for readmission and finalize the customized discharge plan.

3B. Prior to discharge, schedule timely follow-up care and initiate clinical and social services as indicated from the assessment of post-hospital needs and the capabilities of patients and family caregivers.

A high percentage of rehospitalizations occur in the immediate days or weeks following discharge. A national Medicare analysis found 50 percent of patients who were rehospitalized within 30 days had no intervening physician visit between discharge and rehospitalization.³⁰ The Phillips meta-analysis found that comprehensive discharge planning and post-discharge support reduced rehospitalization by 25 percent overall.^{13,14} Strategies included single home visit, increased clinic follow-up, and home visits. In 15 of 18 trials that evaluated cost, multidisciplinary strategies were identified as a key intervention.^{14,25} Surveys of the published evidence reveals the current body of published interventions to reduce rehospitalizations.²⁶⁻²⁹

“How can we develop a post-acute care plan based on the assessed needs and capabilities of the patient and family caregivers?”

Typical failures following discharge from the hospital include the following:

- Medication errors and complexity;
- Discharge instructions that are confusing, contradictory to other instructions, or not tailored to a patient's level of health literacy;
- Lack of scheduled follow-up appointment with appropriate care providers, including specialists;
- Follow-up visit scheduled too long after hospitalization;
- Follow-up visit made the sole responsibility of the patient;

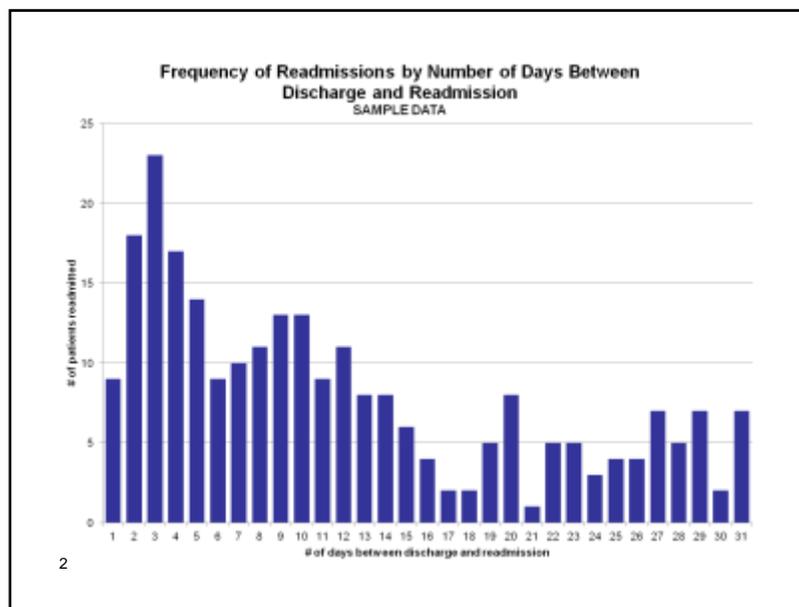
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- Inability of patient to keep follow-up appointments because of illness or transportation issues;
- Multiple clinical care providers, resulting in patient confusion about which provider is in charge;
- Lack of social support and community services for patients;
- Patients' inability to carry out self-care activities (e.g., medications, therapies, daily weights or treatments) because of their lack of comprehension about what they need to do to care for themselves or because they lack resources to comply with self-care plans (financial constraints, lack of transportation, etc.); and
- Inconsistent information being given by various clinical providers (including medication discrepancies).

What are your typical failures and opportunities for improvement?

- Chart the number of readmissions on each day after patients are discharged from the hospital and create a histogram to show patterns. Review these patterns to inform your improvement efforts to initiate a plan of care for each patient to meet assessed needs. See Figure 12 below for an example.

Figure 12: Sample Histogram Showing the Frequency of Readmissions



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- Assess whether the patient's discharge plan is received by the primary care physician and specialists before the patient's scheduled follow-up office visit. Verify the usefulness of the discharge information with these physicians. This could occur during cross-continuum team meetings.

Recommended Changes

3A. Assess the patient's medical and social risk for readmission and finalize the customized discharge plan.

Completing a comprehensive assessment of the post-hospital needs, which began on admission, is an ongoing process that requires the multidisciplinary team to build upon the information throughout the hospital stay to create the individualized discharge plan. Use the findings from this ongoing assessment and the assessment of the patient or family caregiver's understanding of self-care needs to determine the timing and type of follow-up care required by physicians and other health care providers and additional community-based supports needed.

Although a number of risk-assessment tools are reported in the literature, there are inconsistencies regarding which characteristics and/or variables are most predictive of patients who are at risk for rehospitalization.³⁰ Eric Coleman, MD, offers the following guidance regarding identification of patients at high risk for admission:

"Ideally a risk tool would not only identify those at high risk for readmission but more precisely those who have modifiable risk. In other words, risk tools should be aligned with what we understand about how our interventions work and for which patients our interventions work best. In the case of Heart Failure, we should be careful to not assume that the primary readmission for heart failure is after all... the heart. Low health literacy, cognitive impairment, change in health status for a family caregiver, and more may be greater contributors than Left Ventricular ejection fraction. "Asking the patient directly to describe in her or his own words the factors that led to the hospitalization and where they need our support may provide greater insight into risk for return."³¹ The data elements or variables in risk tools available are largely similar. Some require more advanced data capabilities than others. There are inconsistencies regarding which characteristics are most predictive. One possible explanation is that nonpatient

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factors may have a larger role in readmission rates, such as the health care system and access.”

Figure 13 below provides a practical way to assess the patient’s risk for rehospitalization. Ongoing review of patients who are readmitted may add important insights which may inform adaptation to your own criteria for assessing a patient’s risk for readmission.

Figure 13: Categories of a Patient’s Risk of Rehospitalization

High-Risk Patients	Moderate-Risk Patients	Low-Risk Patients
<ul style="list-style-type: none"> • Patient has been admitted two or more times in the past year • Patient or family caregiver is unable to Teach Back, or the patient or family caregiver has a low degree of confidence to carry out self-care at home 	<ul style="list-style-type: none"> • Patient has been admitted once in the past year • Patient or family caregiver is able to Teach Back most of discharge information and has a moderate degree of confidence to carry out self-care at home 	<ul style="list-style-type: none"> • Patient has had no other hospital admissions in the past year • Patient or family caregiver has a high degree of confidence and can Teach Back how to carry out self-care at home

Suggestions for developing a post-acute care plan based on the assessed needs and capabilities of the patient and family caregivers are listed below.

- Develop one comprehensive assessment of post-acute care needs (patient’s needs and capabilities) that integrates input from all members of the care team.
- Change the focus on daily multidisciplinary rounds (MDR) to include a dual focus of optimizing care in the hospital and decreasing the length of stay, while simultaneously planning to meet the post-discharge care needs of patients and prevent readmissions.
- A proposed agenda for MDR or Patient Care Rounds is as follows:
 - What are the goals/reasons for this admission? Are the health care team’s and the patient’s and family’s goals the same?
 - What needs to happen during this hospitalization? What are the criteria that determines the patient’s readiness for discharge?
 - What is the likelihood that this patient will be readmitted in 30 days? If the

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likelihood is high, why?

- What post-acute care plan should be put in place for the patient to mitigate potential problems? Take into consideration the needs and capabilities of the patient and family caregiver(s).
- Initiate the appropriate follow-up care and self-management supports as soon as possible.

3B. Prior to discharge, schedule timely follow-up care and initiate clinical and social services as indicated from the assessment of post-hospital needs and the capabilities of patients and family caregivers.

Scheduling follow-up physician office visits and initiation of home health care and community resources before the patient leaves the hospital is recommended. Teams have succeeded in successfully scheduling appointments by partnering with providers to create a simplified process for scheduling and by getting patient input regarding the best times for them to arrange transportation. Front-loading clinical and support services in the immediate post-hospitalization period has proven to be effective in decreasing rehospitalizations rates for patients with heart failure.³² Hospital staff should create processes for assigning patients to a primary care provider if they do not have one.

Post-discharge follow-up phone calls have been frequently cited as a cost-effective method to assess how the patient and family caregivers are managing self-care needs after discharge from the hospital. These phone calls are generally conducted by clinical staff in the hospital or in clinical settings outside the hospital^{14,33-36} (e.g., heart failure clinics or primary care), by advanced practice nurses or care managers or by staff in call centers. During the calls, the nurses should use Teach Back to verify that the patient: 1) has filled all prescription(s), knows how and when to take medication(s), and understands other critical elements of self-care; 2) recalls why, when, and how to recognize the worsening symptoms and when and whom to call for help; and 3) confirms the date and time of the follow-up physician appointment and has arranged transportation for the visit.

Figure 14 below provides guidance for initiating a post-acute care plan for each level of patients' risk for readmission.

Figure 14: Post-Acute Follow-up Care Based on a Patient’s Risk of Rehospitalization

High-Risk Patients	Moderate-Risk Patients	Low-Risk Patients
<ul style="list-style-type: none"> • Patient has been admitted two or more times in the past year • Patient or family caregiver is unable to Teach Back, or the patient or family caregiver has a low degree of confidence to carry out self-care at home 	<ul style="list-style-type: none"> • Patient has been admitted once in the past year • Patient or family caregiver is able to Teach Back most of discharge information and has a moderate degree of confidence to carry out self-care at home 	<ul style="list-style-type: none"> • Patient has had no other hospital admissions in the past year • Patient or family caregiver has a high degree of confidence and can Teach Back how to carry out self-care at home
Post-acute Follow-up Care		
<p>Prior to discharge:</p> <ul style="list-style-type: none"> • Schedule a face-to-face follow-up visit within 48 hours of discharge. Care teams should assess whether an office visit or home health care is the best option for the patient. • If a home health care visit is scheduled in the first 48 hours, an office visit must also be scheduled within the 5 days. • Initiate intensive care management programs as indicated (if not provided in primary care or in outpatient specialty clinics (e.g heart failure clinics). • Provide 24/7 phone number for advise about questions and concerns. • Initiate a referral to social services and community resources as needed 	<p>Prior to discharge:</p> <ul style="list-style-type: none"> • Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office within 5 to 7 days. • Initiate home health care or transitional care services (eg. CTI) is needed. • Provide 24/7 phone number for advise about questions and concerns. • Initiate a referral to social services and community resources as needed. 	<p>Prior to discharge:</p> <ul style="list-style-type: none"> • Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office visit as ordered by the attending physician. • Provide 24/7 phone number for advise about questions and concerns. • Initiate a referral to social services and community resources as needed.

In a study by Balaban et al, research reports that patients who received an outreach call after discharge had a higher rate of attendance at the scheduled follow-up office visit and had fewer undesirable post-discharge outcomes.³⁷

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Two evidence-based transitional care models for patients who have been discharged from the hospital have shown to be effective in improving care and in reducing avoidable readmissions.

- *The Care Transitions Intervention™ Transitions Coach (Coleman) Model.* Available at www.caretransitions.org. A “Transition Coach” encourage patients to take a more active role in their care and empowers them with skills, tools, and confidence to ensure their needs are met during the transition from hospital to home.
- *Advanced Practice Nurse-Driven Transitional Care (Naylor Model).* [Naylor MD, et al. Transitional care of older adults hospitalized with heart failure. A randomized, controlled trial. *Journal of the American Geriatrics Society*. 2004 May;52(5):675-684.] APNs use an evidenced-based protocol for care, based on national heart failure guidelines and designed especially for this patient care group and their caregivers. APNs design and coordinate care with patients and providers and attend the first post-discharge physician office visit.

Patients who are assessed to be at high risk for readmission should ideally have some form of supplemental intensive care management after discharge from the hospital and in some cases ongoing care management. For more information on a sampling of intensive care management programs for high-risk patients, refer to the following resources:

- *Advanced Practice Nurse-Driven Transitional Care (Naylor Model)* (as described earlier)
- *Evercare Model.* [Kane RL, Keckhafer G, et al. The effect of Evercare on hospital use. *Journal of the American Geriatrics Society*. 2003;51(10):1427-1434.] The nurse practitioner and care managers develop and manage personalized care plans, coordinate multiple services, and help facilitate better communication between physicians, institutions, and patients and families. Care is focused based on patient needs.
- Heart Failure Clinics provide a combination of chronic care and disease management principles, home telemonitoring and work closely with primary care providers. A review of 18 randomized studies showed a reduction in hospital readmissions or shortening of hospitalization with heart failure clinics. [Gustafsson F, Arnold JM. Heart failure clinics and outpatient management: Review of the

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evidence and call for quality assurance. *European Heart Journal*. 2004;25(18):1596-1604.]

- Gilfillan RJ, et al. Value and the medical home: Effects of transformed primary care. *American Journal of Managed Care*. 2010;16(8):607-614.
- Nutting PA, et al. Initial lessons from the first national demonstration project on practice transformation to a patient-centered medical home. *Annals of Family Medicine*. 2009;7(3):254-260.
- *Health Plan Partnership with Disease Management Service*. Blue Shield of California. Available at www.blueshieldca.com/hlr. Features patient-centered management protocols with a complex care team to follow patient closely.
- *Medicare Demonstration Project for High-Cost Beneficiaries*. Massachusetts General Hospital. Available at www.massgeneral.org/News/assets/pdf/CMS_project_phase1FactSheet.pdf.
- *Program of All-inclusive Care for the Elderly (PACE)*. National PACE Association. Available at www.npaonline.org/website/article.asp?id=12. [Nadash P. Two models of managed long-term care: Comparing PACE with a Medicaid-only plan. *Gerontologist*. 2004 Oct;44(5):644-654.]
- *Visiting Nurse Service of New York (VNSNY)*. Available at www.vnsny.org. Focus is on the first 30 days of a patient's transition from one care setting to another, aimed at reducing the number of handovers. It includes all settings: referring provider and facility, VNSNY Care Team, the primary physician and patient/family, community and long-term care/skilled nursing facility.

Recommended Measures ([Data Reporting Guidelines](#), [How-to Guide Resources](#), page 86)

Use this measure to determine the reliability of the processes for scheduling follow-up office visit appointments for patients discharged from the hospital.

- Percent of patients discharged who had a follow-up visit with a physician scheduled before being discharged.

4. Provide Real-Time Handover Communications

Recommended Changes:

4A. Give patient and family members a patient-friendly post-hospital care plan which includes a clear medication list.

4B. Provide customized, real-time critical information to the next clinical care provider(s).

4C. For high-risk patients, a clinician calls the individual(s) listed as the patient's next clinical provider(s) to discuss the patient's status and plan of care.

Clinicians across the health care continuum often provide care without the benefit of having complete information about the patient's condition.²⁰ Don't confuse communication with information. Inadequate transfer of information (the "handover") during care transitions plays a significant role in the problems of quality and safety for patients, contributing to duplication of tests and greater use of acute care services.³⁸

How can we effectively communicate post-acute care plans to patients and community-based providers of care?

There are a few critical elements of patient information that should be available at the time of discharge to community providers. The hospital care team and clinical providers in the next settings of care should agree on the information needed and design reliable processes for information handovers. Written handover communication for high-risk patients is insufficient; direct verbal communication allows for inquiry and clarification.

Patients and families are better able to participate in next steps after hospitalization when they have clear, specific, easy-to-read information. Resources and tools are available to help clinicians provide pertinent information for patients and family caregivers in user-friendly formats.

Typical failures in handover communication include the following:

- Unaddressed medication discrepancies;

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- Discharge plan not communicated in a timely fashion or does not adequately convey important anticipated next steps to the nursing home team, home health care nurses, primary care physician, or family caregiver;
- Current and baseline functional status of the patient are not described, making it difficult to assess progress and prognosis, and the handover discussion is not driven by data;
- Discharge instructions are missing, inadequate, incomplete, or illegible;
- The patient is returning home without essential equipment (e.g., scale, supplemental oxygen, or equipment used to suction respiratory secretions);
- Care processes are unraveling as the patient leaves the hospital (e.g., poorly understood or unidentified cognition issues emerge and the patient is no longer able to manage medications, or the family caregiver is no longer available);
- Lack of an emergency plan with the phone number the patient should call first; and
- Lack of awareness of weaknesses in the patient's social support and the financial implications for the patient of the cost and access to medications.

What are your typical failures and opportunities for improvement?

- Assess the usefulness of handover information through ongoing dialogue with members of the cross-continuum team.
- Review feedback from patients and family members regarding the usefulness of the written discharge plan (HCAHPS scores and narrative feedback).
- Spend one to three hours with a patient on the last day of the hospital stay to identify what went well and what didn't work as planned and predicted during the hospitalization. Use the Observation Guide: Observing Current Discharge Processes (Figure 15) to capture information about what was observed.

Figure 15: [Observation Guide: Observing Current Discharge Processes](#) (How-to Guide Resources, page 106)

Observation Guide: Observing Current Discharge Processes

Observe three patients on the day of discharge (i.e. last day of the hospital stay). Spend one to three hours with each patient and family members to discover what went well, what didn't work as planned or predicted and opportunities for improvement.

What do you predict you will observe?

Recommended Changes

4A. Give patient and family members a patient-friendly post-hospital care plan which includes a clear medication list.

The process of medication reconciliation upon discharge complements the process of medication reconciliation upon admission, although key differences between the two processes exist. All medications should be reconciled on discharge by a suitably trained professional, and a detailed record should be part of the handover report to the next caregivers. On discharge, patients and family caregivers should receive a clear, updated, reconciled, and patient-friendly medication list. This medication list should include clearly stated instructions for how the patient should take the medications and should highlight new medications or changes. The medication list should help the patient and family understand the following:

- The name of each medication (as the patient and family know it) and the reason for taking it;
- Pre-hospital medications that the patient should discontinue (a red stop sign to indicate when a medication should be stopped can be helpful);
- Changes in the dose or frequency compared with pre-hospital instructions;
- Pre-hospital medications that are to be continued with the same instructions;
- Medications and over-the-counter medications that should not be taken; and
- If the patient is being transferred to a skilled nursing facility, reconcile medication discrepancies with the formulary of the community facility.

Encourage patients and families to use a tool or document that does not require reliance on memory, such as a personalized medication list. Figures 16 and 17 provide resources to help patients understand when and how to take their medications.

Figure 16: [How to Create a Pill Card](#) (How-to Guide Resources, page 108)

Also available at www.ahrq.gov/qual/pillcard/pillcard.htm.

How to Create A Pill Card (AHRQ)						
Name: Sarah Smith Pharmacy phone number: 123-456-7890			Date Created: 12/15/07			
Name	Used For	Instructions	Morning	Afternoon	Evening	Night

Figure 17: [User-Friendly Medication Card](#) (How-to Guide Resources, page 108)

Also available at www.ihconline.org/aspx/consumerresources.aspx#MedCard_Anchor.

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

The post-hospital follow-up care presents a critical opportunity to address the conditions that precipitated the hospitalization or rehospitalization and prepare the patient and family caregivers for self-care activities. Suggestions for helping patients and family caregivers to transition to home are noted below:

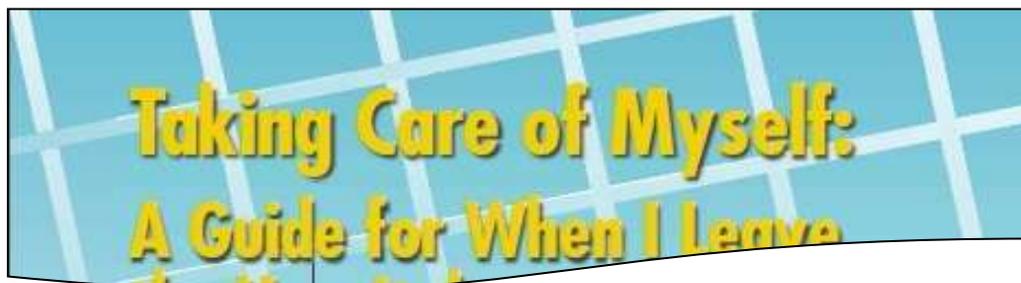
- Ensure that the patient and family caregivers assisting the patient with self-care are present for discharge instructions; ensure they are engaged in the plan and discharge instructions and fully understand what to do once the patient is discharged.
- Provide the patient and family caregivers with written information about what to expect once the patient returns home: easy-to-read self-care instructions, a medication card listing current medications, a list of reasons to call for help, and telephone numbers to call for emergent needs and non-emergent questions. Inform the patient what information to take to follow-up appointments.

- Explore community support systems as needed and provide patients with potential resources to support their ongoing care needs (e.g., Aging Services Networks, Community Centers).
- Plan ahead to keep the patient safe and comfortable on the trip home. Consider the amount of pain medication required to keep the patient comfortable. Investigate whether needed prescriptions can be filled before the patient goes home.

Resources for developing patient-friendly post-hospital care plans:

- *Taking Care of Myself: A Guide for When I Leave the Hospital*, a toolkit (Figure 18) from the Agency for Healthcare Research and Quality (AHRQ) helps patients by answering such questions as: Whom do I contact if I have a problem?; What is my diagnosis?; What medicines have I been prescribed and when should I take them?; Which foods should I eat and what exercises should I do? Which should I avoid?; When are my next medical appointments, and what should I know about them?; What medicines can I safely take for headaches or other health problems?
- Project BOOST has developed a Transition Record (Figure 19) to help patients successfully address situations the patient is likely to encounter after leaving the hospital.

Figure 18: [AHRQ Toolkit - Taking Care of Myself: A Guide for When I Leave the Hospital](#) (How-to Guide Resources, page 109)



Available at www.ahrq.gov/qual/goinghomeguide.htm. Print copies of the bilingual guide (English/Spanish) are available by sending an email to ahrqpubs@ahrq.hhs.gov.

Figure 19: [BOOST Patient PASS: A Transition Record](#) (How-to Guide Resources, page 112)

The image shows a form titled "Patient PASS: A Transition Record" with the subtitle "Patient Preparation to Address Situations (after discharge) Successfully". In the top left corner, there is a logo for "project BOOST" with the tagline "Better Resources for Better Patients through Safe Transitions". The form is divided into three main sections:

- I was in the hospital because:** This section contains a table with two columns: "If I have the following problems ..." and "I should ...". Each column has three numbered rows (1, 2, 3) with horizontal lines for text entry.
- Important contact information:** This section has a heading "Important contact information:" followed by a numbered list starting with "1. My primary doctor:" and a horizontal line for an answer.

Available at
www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/12ClinicalTools/01_Toolkits.cfm.

4B. Provide customized, real-time critical information to the next clinical care provider(s).

Identify the patient's care providers (e.g., physicians, home health care clinicians, and other care providers) and transmit critical information to them at the time of discharge. Ideally, the transmission of critical information precedes or is sent at the time of discharge. Provide an easy-access phone number in the hospital for the clinical care providers to use when questions arise.

Practitioners need an understanding of the patient's baseline functional status, active medical and behavioral health problems, medication regimen, goals, family or support resources, durable medical equipment needs, pending labs and other tests, and the patient's or family caregivers' ability and confidence in providing self-care. Without this critical information, providers may duplicate services, overlook important aspects of the care plan, or convey conflicting information to the patient.³⁷⁻⁴⁰ The "Transitions of Care Consensus Policy Statement" provides guiding principles that address the physician's accountability for creating the discharge summary and for managing care transitions between inpatient and outpatient settings.^{37-42,43} These principles could be used by the multidisciplinary care team to guide planning post-hospital follow-up for all patients.

Leaders of the Hospital to Home (H2H) Initiative has drafted guidance for completing a discharge summary to communicate the patient's care plan and to contribute to the coordination of care (Figure 20).

Figure 20: Hospital to Home Discharge Summary



Discharge Summary and Care Coordination

Discharge summaries serve as the primary vehicle for communicating a patient's care plan once they leave the hospital. They are often the only documentation between a hospital and a patient's next setting of care. Here are core components of a discharge summary gathered from sources relevant to improving care coordination.

Important Parts of a Discharge Summary

The Joint Commission recommends 6 components for a complete discharge summary:¹

1. Reason for hospitalization
2. Significant findings
3. Procedures and treatment provided
4. Patient's discharge condition
5. Patient and family instructions (as appropriate)
6. Attending physician's signature

The National Quality Forum (NQF) recommends 2 fields be included:²

7. A comprehensive and reconciled medication list
8. List of acute medical issues, tests, and studies for which confirmed results were unavailable at the time of discharge and that require follow-up.

Here are 5 additional components identified by experts for inclusion:

9. Final diagnoses (primary and secondary)
10. Discharge destination
11. Follow-up appointments
12. Anticipated problems and suggested interventions
13. Documentation of patient education

Important Note

Every facility has a different discharge summary and there is no one standard format. The most important aspect to a discharge summary is that it is done quickly and that the clinicians who need it, have it at the right time in a patient's care.

¹ The Joint Commission. *Standard IM.6.10, EP 7*.
² NQF. *Safe Practices for Better Healthcare – 2010 Update*. National Quality Forum: Washington, DC. 2010.

Draft Document 6/24/11. © 2011 by the American College of Cardiology

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If the patient is transitioning to home and will be receiving care in a primary care office or specialty practice:

- Ensure that the real-time critical information is sent at the time of discharge and the discharge summary is received by the practice prior to the patient's first follow-up visit.
- Arrange for access to patient discharge instructions in the office practice or encourage the patient or family member to take the discharge instructions to the follow-up office visit.

If the patient is transitioning to a home health care agency, long-term care (LTC), skilled nursing facility, or other care setting in the community, there are some issues to consider when establishing processes for communicating important information about patients at the time of discharge.

- Consider establishing a home health care, skilled nursing facility, or long-term care liaison that will be based in the hospital. For example, one home health care agency provides a hospital-based liaison to assist physicians in daily patient reviews to determine qualification for home health care.
- Work with these liaisons to standardize critical information to be included in a handover communication tool.
- Ask care teams in the receiving care setting for their preferred format and mode of communication and specific information needs.
- Share patient education materials and educational processes across care settings.
- Offer education for the staff in the LTC or SNF, home health care agencies, and community agencies to create bidirectional communication and feedback processes for coordination and greater understanding of the patient and/or family caregiver needs.

The complexity of handovers suggests we need to consider standardized handover forms for the community, region, and state. Figures 21, 22, and 23 are examples of transition forms that have been used a variety of organizations and communities.

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Figure 21: [Michigan Ticket to Ride Transition Form](#) (How-to Guide Resources, page 113)

The form is titled "Michigan Ticket to Ride: Transition Form". It includes two rows of checkboxes for "Coming from:" and "Transition To:", each with options for Extended care, Home care, Hospital, Acute rehabilitation, Assisted living, and Hospice. Below this is a section for "DEMOGRAPHIC INFORMATION (PLEASE ATTACH THE PATIENT'S FACE SHEET)" with fields for Date, Transition coordinator, Phone#, Pt name, DOB, Address of care, Contact person, Relation, and Guardian - Name.

Figure 22: [Puget Sound Heart Failure Care Transition Summary Form](#) (How-to Guide Resources, page 115)

The form is titled "Puget Sound Heart Failure Care Transition Summary Form SAVEABLE 11 02 2009 (2).txt". It features a header with the WPSU logo and contact information. The main body contains fields for Patient Name (John Doe), Date of Birth (04/20/33), Medical Record Number (222222), Care Facility (Marionview), Facility Type (Hospital), Admitted/Discharged/Transferred dates (07/02/09, 07/07/09, 07/07/09), and a section for Heart Failure Diagnosis with checkboxes for Acute on Chronic and Systolic (EF < 40%) Heart Failure.

Figure 23: [Akron Regional Hospital Association Post-Acute Transfer Form](#) (How-to Guide Resources, page 116)

The form is titled "AKRON REGIONAL HOSPITAL ASSOCIATION" and is dated "Revised 2/21/2007". It includes a list of checkboxes for various hospitals and medical centers, such as Affinity Doctors, Mercy Medical Center, Regency Hospital - Barberton, and others. Below the list are sections for "POST-ACUTE TRANSFER FORM - PHYSICIAN ORDERS" and "MEDICAL INFORMATION", along with a "SPECIAL CARE ORDERS" section containing checkboxes for ENEMAS PRN, O2 LITER FLOW, and IV CARE/PRN.

4C. 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.

Written handover communication for high-risk patients however is insufficient. We should not assume written information will provide all the needed details. Direct verbal communication is needed in these high-risk cases to allow for dialogue about the patient's clinical status as well as opportunities for inquiry and clarification about the plan of care. A personal phone call or "warm handover" communication with the next clinical provider provides a mechanism for

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bidirectional communication and a better understanding of the patient and family caregiver needs.

Recommended Measures ([Data Reporting Guidelines](#), **How-to Guide Resources,
page 86)**

Use these measures to determine the reliability of your processes for providing patients and their outpatient care providers with timely and appropriate information.

- Percent of patients discharged who receive a customized discharge plan written in patient-friendly language at the time of discharge.
- Percent of discharges where critical information is transmitted at the time of discharge to the next site of care (e.g., home health, long-term care facility, rehabilitation care, physician office).

III. Design Elements

The design elements or principles for improving care transitions and coordination of care after patients are discharged from the hospital include: 1) patient and family caregiver engagement, 2) cross-continuum team collaboration, and 3) health information exchange and shared care plans. These cross-cutting principles are catalysts for the successful implementation of the key strategies and changes to improve care transitions and to reduce avoidable rehospitalizations.

Patient and Family Caregiver Engagement

Engagement with patients and their family caregivers takes many forms, including partnerships in treatment and shared care planning, improving care across the continuum, redesigning care and service processes, and optimizing communication between health care providers and patients and their family caregivers.

At the annual IHI National Forum in 2002, Don Berwick asked, “Are patients and families someone to whom we provide care? Or, are they active partners in managing or redesigning their care?” If we truly want to transform care processes, patients and families know the “white spaces” between services and locations of care. Patients and family caregivers should be engaged in choices, planning, and decisions about their care. We also need them engaged in the redesign of care processes if we are to achieve patient- and family-centered care.

The challenges for health care leaders “Start Before You Are Ready!” has been stated by Jim Anderson, former Chairman of the Board at Cincinnati Children’s Hospital and Medical Center. Figure 24 is a document on which IHI collaborated with leaders at Cincinnati Children’s Hospital to develop a readiness assessment for *Partnering with Patients and Families to Accelerate Improvement*.

Figure 24. [Readiness Assessment](#) (How-to Guide Resources, page 120)

Partnering with Patients and Families to Accelerate Improvement
Readiness Assessment

Name of Organization _____

Area	Current Experience: make a mark (an X, a circle, or anything that is easy to read) in the box that best describes your team or organization's experience.
Data transparency	We have not discussed the possibility of sharing performance data with
	Our team is comfortable with sharing improvement

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At St. Luke's Hospital in Cedar Rapids, Iowa, the Patient and Family Advisory Council (FAC) for Heart Care Services is dedicated to helping the service fulfill its mission: "To give the health care we'd like our loved ones to receive" and to support the principles and practice of family-centered care. Functions of the FAC include providing input and feedback on ways to improve:

- Patient and family experience;
- Delivery of services for patients and families;
- Educational programs, classes, and written materials for patients;
- Program development such as for the transitions in care team;
- Education/orientation of hospital associates;
- Facility design or renovation;
- Reviewing accomplishments and setting goals; and
- Recruiting new members.

For more information on partnering with patients and families to transform care refer to:

Partnering with Patients and Families to Design a Patient- and Family-Centered Health Care System: A Roadmap for the Future. Institute for Healthcare Improvement. Available at www.ihl.org/knowledge/Pages/Publications/PartneringwithPatientsandFamilies.aspx.

Tools for Advancing the Practice of Patient- and Family-Centered Care. Institute for Patient- and Family-Centered Care. Available at www.ipfcc.org/tools/downloads.html.

Berwick D. What 'patient-centered' should mean: Confessions of an extremist. *Health Affairs (Millwood)*. 2009 Jul-Aug;28(4):w555-65. Epub 2009 May 19.

Taylor J, Rutherford P. The pursuit of genuine partnerships with patients and family members: The challenge and opportunity for executive leaders. *Health Services Management*. 2010 Summer;26(4):3-14. Available at www.ihl.org/knowledge/Pages/Publications/PursuitGenuinePartnershipswithPatientsFamily.aspx.

Cross-Continuum Team Collaboration

Cross-continuum team collaboration is a transformational hallmark of the STAAR initiative that promotes the paradigm shift from site-specific care to patient-centered care, where the focus is on the patient's experience over time. Understanding mutual interdependencies between care settings, the hospital-based teams co-design care processes with their community-based clinicians and staff and collaborate to improve patients' transition out of the hospital and reception into community settings of care. This collaborative teamwork reinforces that readmissions are not solely a hospital problem.

Leadership for successful cross-continuum teams varies. Some are initiated by hospital executives who invite representatives from community-based sites of care and community agencies that received their patients to learn and test changes in collaboration with hospital-based teams. Quality Improvement Organizations (QIOs) are bringing together hospitals, nursing homes, patient advocacy organizations, and other stakeholders in community coalitions where in many cases leadership arises from a community-based leader. Regardless of the initial leadership, the purpose of the cross-continuum team collaboration is to work together toward a common goal and to co-design care transition processes that keep patients safe during the transitions between care settings and to coordinate the care of patients.

The cross-continuum team should meet regularly to facilitate communications and collaboration, assess progress, remove barriers to progress, and support improvement efforts of the front-line teams in all clinical settings. In the STAAR initiative, a few key roles for cross-continuum teams are emerging and are delineated below.

Oversight Role

- Identify opportunities and establish aims to improve care transitions.
 - Surface failures and diagnose systemic gaps in care transitions and identify and/or test new ideas;
 - Review and analyze the readmission data and data about patient/family experiences;
 - Complete periodic diagnostic reviews of cases where patients have been readmitted to engage all clinicians and staff in the community and to continually learn about opportunities for improvement; and

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- Create a common aim and look at linkages of processes where cooperation is required.
- Build capability to partner with patients and family caregivers.
 - Add patients and family caregivers to the cross-continuum team to enhance the focus on patient/family experiences and to enable their participation in improving care processes.
- Build capability and capacity in partnering across organizational boundaries.
 - Develop mutual familiarity with the characteristics and needs of each setting by having members from the cross-continuum team visit each others' sites to observe patient care processes during transitions (e.g., hospital and home care nurses shadow each other in the hospital and home visits); and
 - Rotate meetings in the different sites.

Portfolio Management

- Review the comprehensive results and progress over time and support the work of front-line clinicians and staff in the hospital, office practice settings, home health care, and skilled nursing facilities in the co-design and implementation of processes to improve transitions in care.
- Manage a portfolio of community-wide improvement initiatives and review progress of each initiative. Examples of community-wide initiatives include:
 - Create universal handover forms/formats to improve communication and coordination of patient care among all clinical settings;
 - Develop a common evidence-based patient education approach in all clinical settings (e.g., health literacy strategies);
 - Create universal teaching materials for the most common clinical conditions for use in all clinical settings; and
 - Create universal self-management tools to be used in all clinical settings to support patients and family caregivers.
- Facilitate collaboration along with payers and post-acute care providers to determine eligibility criteria for intensive care management and how to determine the clinical provider who is “in charge of coordinating care” for various patient populations (Care Transitions Intervention, APN Transitional Care, HF Clinic, Patient-Centered Home, Evercare, etc.).

Health Information Exchange and Shared Care Plans

Health information technology (HIT) and the systems to enable the exchange of electronic information within and across settings in a community (i.e., interoperability) can have a dramatic effect on the coordination and communication of information among providers and between providers and patients. While hospitals have had electronic systems to support financial and management systems for a long time, fewer have electronic clinical information systems that support quality of patient care.⁴¹ Other settings across the continuum of care have only recently begun to adapt and implement HIT systems that include clinical information.⁴³ Recent national initiatives — such as the Health Information Technology for Economic and Clinical Health (HITECH) Act (P.L. 111-5) that has as its goal the adoption of HIT in hospitals and office practices around the country — are helping to accelerate the use of HIT more broadly across the health care system. Some insights about the current and potential impact of HIT on the components of IHI's Roadmap for Improving Transitions in Care after Hospitalization and Reducing Avoidable Rehospitalizations (Figure 1) are addressed in this section of the How-to Guide.

Transition from Hospital to Home

During the hospitalization, the ability of clinicians and staff to complete an enhanced assessment and create a post-discharge care plan can be done more consistently and easily if they have immediate access to information about the patient from a number of sources, including primary care and other community providers as well as from members of the care team within the hospital. Medication reconciliation is more effectively accomplished with shared access to patient records across providers. Information gained about the patient during Teach Back sessions, whether conducted in the hospital or in the primary care office, can become part of a continuous documentation of a patient's and their family caregivers' ability to understand how to take care of the patient with the use of shared information systems. Shared care plans, such as the Patient Powered system developed in Whatcom County, Washington, can be the vehicle for engaging patients in the development of their care plans and also in the active management of their health in an ongoing way. With shared care plans, patients have direct access to their medical information and designate others with whom they want to share the information.

Post-Acute Care Patient Activation

The ability of clinicians and staff in skilled nursing facilities, home health care, and primary care practices to effectively receive the patient following a hospitalization depends on their having access to information about the patient's course of treatment and the care plan developed during the hospitalization. The timely transmission of the discharge summary is often a key roadblock that can be addressed through shared access to the patient's medical record and the key recommendations for follow-up care by the discharging physician.

HIT systems can also play a role in standardizing patient-focused information about the illness and ensuring that the patient receives complementary information across settings and sites of care. In addition HIT has the potential to capture how effectively the patient and family caregivers are able to Teach Back what they are learning, share that information with clinicians across settings, and link engagement strategies to the level of patient activation.

Evidence-Based Care in Community Care Settings (Better Models of Care)

Information technology enables clinicians and staff in all settings to better manage care for their patients by having access to information about medication history, past treatments, outstanding tests, patient and family understanding of and ability to care for the patient, and patterns of hospitalization and ED use. For example, information technology enhances the ability of primary care practices to practice population management (i.e., to understand the needs of entire populations of patients with specific clinical conditions or multiple clinical conditions and provide proactive care to meet those needs).

Alternative or Supplemental Care for High-Risk Patients

Technology and information systems can be used to provide enhanced care to those at high risk of readmission by enabling not only daily monitoring of key clinical information about the patient, but also daily contact between the patient and his or her care team. For example, a number of approaches to providing enhanced or supplemental care to high-risk patients combine intensive contact and support with some type of telemedicine.

In spite of the potential that HIT has to impact improvements in transitions in care, there are a number of limitations of current HIT systems, including the lack of connectivity between different HIT systems in different settings (e.g., between hospitals and practices or skilled nursing facilities). Even within a single care setting such as a hospital, the systems for data exchange

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are not transparent and do not encompass all of the elements. Most hospitals have fragmented care plans by discipline (different ones for MDs, RNs, pharmacists, etc.). While the HITECH Act also provides funding to support the state and regional efforts that will enable the transfer of electronic data across all settings and sites of care, fully functioning systems are not widespread. The Office of the National Coordinator recently released a Request for Information (RFI) on Governance of the Nationwide Health Information Network to a common set of “rules of the road” for privacy, security, business and technical requirements that will help create the necessary foundation to enable the nation’s electronic health information exchange capacity to grow.⁴²

In addition to the technical issues that need to be solved, there are other challenges that need to be addressed in order to fully maximize these systems to help providers and patients improve transitions, including better partnership between IT vendors and quality improvement experts and overcoming the conflict between vendor business strategies and the needs of providers within and/or across regions.

IV. Infrastructure and Strategy to Achieve Results

Step 1. Executive Leadership

The Executive Sponsor links the goals of improving transitions in care and reducing readmissions to the strategic priorities of the organization. The sponsor provides oversight and guidance to the improvement teams' work. Depending on the size and organizational structure of the hospital or health care system, typical Executive Sponsors may include Chief Executive or Chief Operating Officers, Patient Safety Officers, Medical Directors, Nurse Executives, or Community Leaders.

If reducing readmissions and improving readmissions lack strategic priority, the chances of achieving lasting results lessen. These strategic questions may help frame the initiative:

- Is reducing the hospital's readmission rate a strategic priority? What competing commitments might interfere with this work?
- What initiatives or other projects to reduce readmissions are already underway or planned? Are they aligned?
- What resources and expertise in quality improvement and data analysis will support improvement efforts?
- How will leaders provide oversight and accountability for the improvement projects?

The Executive Sponsor should also select a Day-to-Day Leader who coordinates project activities; helps lead the cross-continuum team; provides guidance to the front-line improvement team(s); and communicates progress to the Executive Sponsor on a regular basis. The Day-to-Day Leader is often a quality improvement leader, a nurse director, or a director of case management.

The Executive Sponsor guides breakthrough performance. IHI's white paper *Execution of Strategic Improvement Initiatives to Produce System-Level Results*, contains four components to achieve results:⁴⁴

1. Set priorities and breakthrough performance goals;
2. Develop a portfolio of projects to support the goals;

3. Deploy resources appropriate for the aim; and
4. Establish an oversight and learning system to produce desired change.⁴⁴

Step 2. Convene a Cross-Continuum Collaboration Team

A multistakeholder team that is composed of representatives from across the care continuum, including patients and family caregivers, provides leadership and oversight for the portfolio of projects. This team co-designs the processes to improve transitions in care. It identifies “sender” and “receiver” relationships for every step of the patient journey across the care continuum. Collectively, team members explore ideal information flow as the patient moves from one setting to the next. Cross-continuum collaboration team membership may include:

- Patients and family caregivers (*ideally these are not retired health care professionals*)
- Hospital staff such as nurse managers, nurse educators, and staff nurses; hospital physicians or hospitalists; case managers; pharmacists; discharge planners; or quality improvement leaders
- Staff from skilled nursing facilities and long-term care centers
- Office practice representatives like primary care physicians and specialists; nurses or nurse practitioners; or practice administrators
- Home health nurses and staff; palliative care, hospice nurses and staff
- Community pharmacists
- Community social services agencies staff such as case managers or staff from elder services

Step 3. Identify Improvement Opportunities

The first cross-continuum collaboration team or multistakeholder team meets and defines its aspirations and purpose. It develops a plan to manage the improvement portfolio and clarifies its aim (e.g., to reduce rehospitalizations by 30 percent). Early team tasks include a diagnostic assessment (see Step 3a, below) and review of historic data like readmission rates, transfers from long-term care centers to hospitals, patient perception data, home health admissions to acute care, and the like.

Step 3a. An in-depth medical record review of the last five rehospitalizations yields rich information. The Diagnostic Worksheet helps make sense of these findings (Figure 25).

Figure 25: [Diagnostic Worksheet \(Part 1\)](#) (How-to Guide Resources, page 122)

Diagnostic Worksheet: In-depth Review of Patients Who Were Readmitted					
Part 1: Chart Reviews of Patients					
Conduct chart reviews of the last five readmitted patients. Reviewers should be physicians or nurses experienced in the clinical setting and in chart review for quality and safety. Reviewers should not look to assign blame, but rather to discover opportunities to improve the care of patients. Worksheet A3 is a reference list of typical failures. The intent is to learn how we might prevent these failures that we once thought impossible to prevent.					
Question	Patient #1	Patient #2	Patient #3	Patient #4	Patient #5
Number of days between the last discharge and this readmission date?	_____ days				
Was the follow-up physician visit scheduled prior to discharge?	Yes <input type="checkbox"/> No <input type="checkbox"/>				

- Interview five patients recently readmitted (ideally, while in the hospital) and their family members. If possible, interview the same patients whose charts were reviewed. Next, conduct interviews with community clinicians who know the readmitted patient (e.g., physicians, nurses in the skilled nursing facility, home health nurses, etc.). Identify problem areas from their perspective. Transcribe information from these interviews onto Part 2 of the Diagnostic Worksheet (Figure 26).

Figure 26: [Diagnostic Worksheet \(Part 2\)](#) (How-to Guide Resources, page 124)

Diagnostic Worksheet: In-depth Review of Patients Who Were Readmitted	
Part 2: Interviews with Patients, Family Members, and Care Team Members in the Community	
If possible, conduct the interviews on the same patients from the chart review. <u>Use a separate worksheet for each interview.</u>	
Ask Patients and Family Members: How do you think you became sick enough to come back to the hospital? <input type="text"/>	
Did you see your doctor or the doctor's nurse in the office before you came back to the hospital? Yes <input type="checkbox"/> If yes, which doctor (PCP or specialist) did you see? <input type="text"/> No <input type="checkbox"/> If no, why not? <input type="text"/>	

Kaiser Permanente deepens its patient experience understanding with video ethnography. See <http://kpcmi.org/news/ethnography/video-ethnography-tool-kit.pdf>.

St. Luke's Hospital in Cedar Rapids, Iowa, Diagnostic Review revealed this patient story:

James, a 68-year-old man, lives at home with Martha, his wife of 48 years. He was admitted to the hospital with shortness of breath and diagnosed with pneumonia and underlying onset of heart failure. He and Martha were provided with instructions about new medications and diet before discharge and asked

to see his physician in the office in two weeks. A few days after returning home, Martha reminded James to schedule his visit to the physician's office, but James had difficulty reaching the scheduler. Finally, he was able to set up a visit for three weeks later.

James didn't mention to Martha that he took the three-day supply of Lasix the hospital sent home with him but never filled his prescription; he felt well again and thought the expense unnecessary. When he noticed swelling in his legs, he didn't want to bother the "busy doctor" and dreaded the ordeal of calling the office again.

After 11 days, James was readmitted to the hospital with increased shortness of breath, marked edema of his lower legs, a weight gain of 25 pounds, and mildly elevated brain natriuretic peptide (BNP), a marker of cardiac insufficiency. His hospital stay went well, but James' stress level was high, his blood pressure was elevated, and another drug was added to his medication regimen.

While James was in the hospital, Martha was admitted for an emergent surgery. After his discharge, James began eating in fast food restaurants as he worried about his wife, juggled visits to Martha's bedside, and managed a roofing project on their home. The day Martha came home from the hospital, James was readmitted with exacerbation of heart failure.

Step 3b. Review patient experience data about communications and discharge preparations.

Trend the data for the questions below from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient response data in a time series chart for the entire hospital, by month, for the last 12 months (www.hcahpsonline.org). Refer to [Patient Experience Measures](#), page 87).

- “Did hospital staff talk with you about whether you would have the help you needed when you left the hospital?” (HCAHPS Q19)
- “Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?” (HCAHPS Q20)

Step 3c. Trend the 30-day all-cause readmission and the number of patients admitted to observation status in time series charts.

Collect historical data and display monthly all-cause readmission rates in a time series chart. Display data for the last 12 months, if possible. Consider segmenting readmissions rates by patients with certain diagnoses like heart failure. Additional outcome measures are recommended.

Recommended Readmissions Measures

- 30-day all-cause readmissions
- Readmissions count
- 30-day all-cause readmissions for a specific clinical condition
- The number of patients admitted for observation status

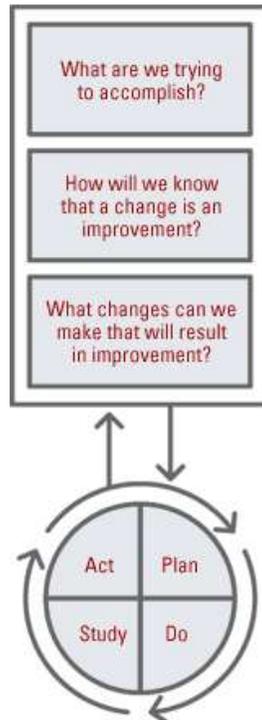
Step 4. Use the Model for Improvement

Developed by Associates in Process Improvement, the Model for Improvement (Figure 27) is a simple yet powerful tool for accelerating improvement that has been used successfully by hundreds of health care organizations.

The model has two parts:

- Three fundamental questions that guide improvement teams to 1) set clear aims, 2) establish measures that show if changes lead to improvement, and 3) identify changes that are likely to lead to improvement.
- The Plan-Do-Study-Act (PDSA) cycle to conduct small-scale tests of change in real work settings — by planning a test, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented process improvement.

Figure 27: The Model for Improvement



Learn more about the Model for Improvement at www.ihl.org.

Question 1: What are we trying to accomplish?

Craft an aim statement to guide the work. Aim statements communicate what a team hopes to accomplish and the magnitude of its change. Aim statements have four parts to them: what the team expects to do; by when; for whom, and states the measurable goals.

Example aim statements:

1. *St. Elsewhere Hospital will improve transitions home for all patients as measured by a decrease in the 30-day all-cause hospital readmission rate from 12% to 8% percent or less within 24 months.*

We will start our improvement work with patients on 4W and 5S. We will expect to see a decrease in the readmission rates for patients discharged from those units of at least 10% within 12 months.

2. *Shady Oaks Hospital will improve transitions home for all heart failure patients as measured by a reduction in unplanned 30-day all-cause readmission rates for heart failure patients (decreasing the rate from 25% to 15% or less in 18 months).*

For more on setting aims, please refer to:

www.ihl.org/knowledge/Pages/HowtoImprove/ScienceofImprovementSettingAims.aspx.

How to Select Pilot Units or a Pilot Population

Based on what is learned about 30-day all-cause readmission data, select one or two medical/surgical units where readmissions occur the most. If one patient population accounts for a large percent of the readmissions (e.g., heart failure patients; patients transferred from long-term care centers) it may help to focus initially on this patient segment.

How to Form an Improvement Team

Front-line improvement team(s) vary from hospital to hospital. Ideally, involve individuals who actively assess patients, teach and facilitate patient education, communicate essential information during handovers to the next care setting, and arrange post-hospital care follow-up. Front-line improvement team(s) will initially test the 4 Key Changes on the unit(s). A typical front-line improvement team includes:

- A Day-to-Day Leader for each pilot unit who will drive the work on their respective unit(s);
- Patients and family members;
- Physician champions (this person may be a cardiologist, intensivist, hospitalist, primary care physician, or specialist, depending on the specific unit selected);
- Nurse manager, staff nurses, case managers, clinical nurse specialists, and nurse educators;
- Social workers and/or discharge planners;
- Pharmacists; and
- Clinicians and staff from community settings.

Question 2: How will we know that a change is an improvement?

Data to reduce readmissions and rehospitalizations is best for learning not judgment.

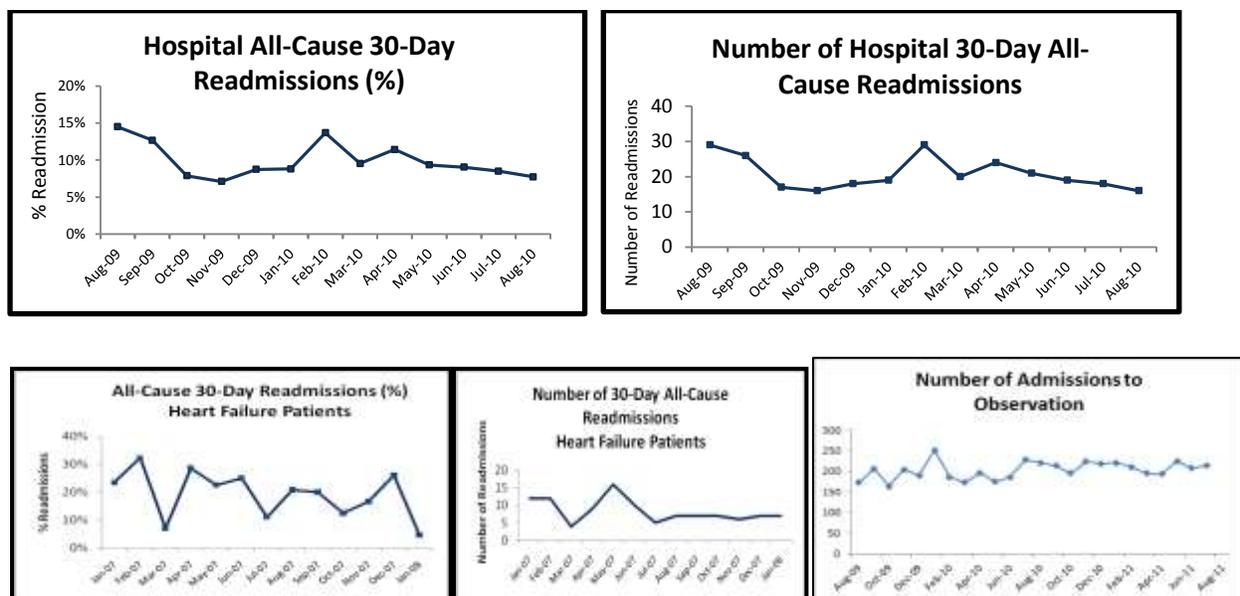
Outcome, process, and balancing measures inform improvement. Outcome measures directly

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relate to the aim — in this case, to reduce readmissions or rehospitalizations. Process measures reflect how work gets done around the key changes. Balancing measures help ensure that we are not causing detriment to an important part of the system. When data is displayed in a time series graph or in a run chart trends and improvement are easy to observe (Figure 28).

A comprehensive list of all of the measures can be found in the [System Measures Section](#) on page 86.

Figure 28: Example Run Charts for Outcome Measures for Readmission, Patient Experience, and Balancing Measures



Question 3: What changes can we make that will result in improvement?

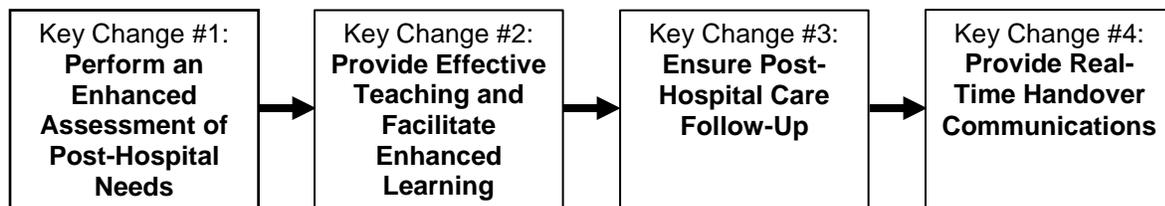
Select the changes needed to bring about improvement from among the Key Changes outlined in section II.

The key changes represent the temporal journal of a patient hospital stay. First, the patient is admitted and the key change for avoiding a subsequent readmission is an assessment of the specific patient needs at discharge. The second key change occurs during the hospital stay and involves using Teach Back to improve teaching and assess patient or the designated learners understanding. The third key change is preparing for follow up after discharge. The

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final change provides the person who receives the patient information needed. All changes should be reliably implemented and scaled up across the hospital to reduce readmissions.

Figure 29: Flowchart of Key Changes



Using PDSA Cycles for Learning and Improvement

The engine of improvement is the Plan-Do-Study-Act (PDSA) cycle. A team conducts small-scale tests of change in real work settings — by planning a test, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented process improvement.

Additionally, observation may inform improvement because it yields significant learning as a team tests and then implements changes.⁴⁵⁻⁴⁸ The key change descriptions include suggestions for observation.

Why Test Changes?

- To increase your belief that the change will result in improvement
- To decide which of several proposed changes will lead to the desired improvement
- To evaluate how much improvement can be expected from the change
- To decide whether the proposed change will work in the actual environment of interest
- To decide which combinations of changes will have the desired effects on the important measures of quality
- To evaluate costs, social impact, and side effects from a proposed change
- To minimize resistance upon implementation

How to Test a Change

A first test of change usually happens on a small scale (e.g., using Teach Back with one nurse or one patient or for one day). Use a Plan-Do Study-Act format and predict what will happen as a result of trying something different. Observe the results, learn from them, and continue to the next test. Use iterative PDSA cycles to test under a variety of conditions. This improves the team's belief that the change will work reliably when implemented. See the PDSA Worksheet (Figures 30 and 31).

Figure 30: [PDSA Worksheet](#) (How-to Guide Resources, page 127)

MODEL FOR IMPROVEMENT DATE _____

Change or idea evaluated: _____

Objective for this PDSA Cycle: _____

Figure 31: [Example Completed PDSA Worksheet](#) (How-to Guide Resources, page 128)

MODEL FOR IMPROVEMENT DATE __8/10/2010__

Change or idea evaluated: __Use HF Zone handout to improve pt learning__

Objective for this PDSA Cycle: __Improve pt understanding of HF using the zone worksheet, improve nurse teach__

Most changes require a series of successive tests before implementation. Testing may include adding more staff to try the change, adding a variety of types of patients and families, or testing on different shifts, on the weekdays and on the weekends, when short staffed, well staffed, on days with many admissions, few admissions, etc. The point is to learn as much as possible and create a process that is reliable as. A series tests are outlined below.

Example of Iterative PDSA Cycles to Improve Patient Understanding Using Teach Back

- Cycle 1: One nurse, on one day, tests whether using Teach Back with one patient who has heart failure (HF) helps the patient learn the reasons to call the

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physician for help after discharge. The nurse learned that materials were confusing to the patient.

- Cycle 2: Nurse revises the teaching materials to identify key points by circling them. The nurse runs a second PDSA cycle with the same patient the next day and the patient can Teach Back the signs and symptoms, when and how to call his doctor.
- Cycle 3: The nurse expands Teach Back to two patients, one has a designated learner, his daughter.
- Cycle 4: The nurse tries a cycle of setting a learning appointment with a designated learner. This cycle is later abandoned due to complexity.
- Cycle 5: Nurse expands Teach Back to all patients with heart failure and spreads out the Teach Back sessions over several days during the stay.
- Cycle 6: Nurse expands Teach Back to all her patients and designated learners.
- Cycle 7: Teach Back is introduced to the weekend staff and two nurses from each shift are trained. Nurses begin sharing results of learning in shift report to coordinate who teaches what.
- Cycle 8: The nurse manager observes that staff struggle with how to ask the patients to Teach Back and develops 3 alternative scripts for testing.
- Cycle 9: Staff try the scripts and like two of the three, they adopt those two.

Suggestions for Conducting PDSA Cycles

- Keep tests small; be specific.
- Make a prediction about what will happen if the tests succeeds.
- Each test informs the next.
- Expand test conditions to determine whether a change will work under a variety of conditions:
 - Different times of day (e.g., day and night shifts, weekends, holidays) when the unit is adequately staffed;
 - At times of staffing challenges; or
 - Different types of patients (those with lower health literacy, non-English speaking patients, short stay or long stay patients).
- Collect sufficient data to evaluate whether a test has promise, was successful, or needs adjustment. Compare data to findings to learn more and design future tests.

Test to Increase Process Reliability

David Garvin defines reliability as failure free operation over time. Processes should get desired results every time, for every appropriate patient. As PDSA cycles ramp up, make sure to precisely specify the work, who does what, when, how, where, etc. To make processes more reliable make use of human factors principles (e.g., build on existing habits, use checklists to avoid relying on memory, foolproof the process so that it is impossible to do the wrong thing, use standard protocols and training). To increase reliability, for example, consider auto-reminders for Teach Back and documentation. Another method for developing reliability is to interview staff about how they do particular work, like patient teaching and the use of Teach Back. If the responses vary, this may reveal a lack of reliability in how the work is done. Peer observers and coaches help to build new competencies among the staff.

Make sure there is a process in place that identifies failures (e.g., a patient is ready for discharge but never received any Teach Back during their stay, or a patient cannot Teach Back important aspects of their self-care and nothing was changed in the discharge plan).

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Learn where failures occur and then use problem-solving to design solutions redundancies or remedies if they occur.

Improving Reliability of Teach Back: When redesigning your patient education processes to teach patients about home-going instructions (as described in the example PDSA cycles above), work with staff who conduct the tests to precisely describe the work. The following questions may help improve reliability and specify work. Below is an example of how to customize the questions around Teach Back.

- *Who will do it (be specific — e.g., include the name of the nurse assigned to the patient)?*
- *What will they do (e.g., use Ask Me 3™ framework to organize teaching for all patients and each patient is asked [in a non-shaming way] to describe in their own words what was learned)? Learning is documented in the patient's record so that at discharge, details on the patient's ability to Teach Back the key points can be transferred to the next site of care.*
- *When will they do it (e.g., during second hourly rounding of shift)?*
- *Where will they do it (e.g., in the patient's room)?*
- *How do they do it (include tools that are used — e.g., Teach Back documentation tool kept in patient's chart)?*
- *How often will they do it (e.g., once each day)?*
- *Why should they do it (e.g., to enhance learning and identify patients who are at risk for problems while caring for themselves post-discharge)?*

Continue to test the process under a variety of conditions (e.g., different nurses, different kinds of patients). Adapt the change iteratively until it optimally meets the needs of both patients and staff and a high level of reliability is achieved (i.e., the process works as designed at least 95 percent of the time).

Learn from failure as well as from success. Understanding common failures (situations when a process is not executed as expected) helps the team to (re)design the new processes to eliminate those failures.

Learning from a failed test:

The nurses used the Ask Me 3™ framework and Teach Back with all patients. A nurse caring for a patient with chronic depression was unsure about the relevant Teach Back questions to assist her with patient education. The nurses, physicians, and social workers met to delineate the relevant Teach Back questions for patients with mental health conditions and redesigned education.

After successful testing under varying conditions with desired results, document the process so there is no ambiguity and all involved can articulate the exact same steps in the process.

Use Data, Displayed Over Time, to Understand Progress

Use data to assess process reliability. For example, display in a time series graph the percentage of patients who can Teach Back two-thirds or more educational material. Another useful measure is the percentage of observations of teaching opportunities where nurses use Teach Back. Annotate graphs to note when specific changes are implemented. Continue to collect and display this data to see whether your changes result in improvement. Augment quantitative data with information from asking patients about their experience (consider using the [Diagnostic Worksheet](#), How-to Guide Resources, page 122).

Track whether new and improved processes are executed as expected with process measures. Learn whether and how specific changes work as planned. Figure 32 shows an example of an annotated time series graph for a process measure for *Provide Effective Teaching and Facilitate Enhanced Learning*. The annotations show when specific changes were tested or implemented.

Figure 32: Example Time Series Graph for Process Measure



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When data suggest a lack of process reliability — ask the people who do the job what barriers they face. Identify opportunities to execute the new processes more reliably. Avoid blaming staff who do the work. Assume the problem is from poor process design. Work with the team to fix it. For example, if the team observes that nurses are not using Teach Back, the team should ask nurses about barriers to using Teach Back and then improve the likelihood Teach Back will be used.

Note, for example, how the data in the graph above (Figure 32) enables the team to see when performance declined and test new interventions to improve reliability. Share data with unit staff, physicians, and senior leaders. Reflect on lessons learned from both successful and unsuccessful tests of change.

Step 5. Implementation, Scale-up, and Spread

Implementation of Changes

After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team should broadly implement the change to make it permanent and routine. This usually requires revisions to written policies, hiring, training, compensation, equipment, and other aspects of the organization's infrastructure that were not engaged in the testing phase. Pay attention to communication (i.e., publicizing the benefits of the change), documenting improvement, as well as keeping in contact with the pilot team to support it during implementation.

Implementation Example: During the testing process, a few nurses learned Teach Back. Once the processes and support materials have been adapted so that these nurses teach the identified learners effectively over 90 percent of the time, those processes should be implemented across the unit. Making these processes the default system (i.e., the way the work is done rather than the way a few nurses do the work from time to time) requires a training system for all nurses currently on the unit, and changes to orientation programs for new nurses. To scale up the change across the hospital might require changes to an IT documentation system. Communication to all staff about new expectations for teaching and learning might be developed to generate interest in implementing the redesigned process in other parts of the hospital (e.g., in other units or service lines) or with other disciplines (like physicians, or pharmacists) in preparation for spread.

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During implementation, attend to social aspects of the change as well as the technical infrastructure. Leaders need to communicate the *why* as well as the *how* of the change, and address questions and concerns. It is common for processes to work reliably during testing and less reliably, temporarily, during implementation because a larger group, some unfamiliar and/or unsympathetic with the purpose, must implement a change.⁴⁹ There may be resistance, or simply confusion. It may take some cycles of testing to put in place an effective infrastructure to support the change(s). After implementation, continue to monitor whether processes are reliable and act on that information to adapt the processes and the related infrastructure to support the change. Make it easy to do the right thing, and hard to do the wrong thing.

Tips for Sustaining Improvements

- Communicate aims and successful changes that achieved the desired results (e.g., newsletters, storyboards, patient stories, etc.).
- “Hardwire” processes so that the new processes are difficult to reverse (e.g., IT template, yearly competencies, role descriptions, policies and procedures).
- Assign ownership for oversight and ongoing quality control to “hold the gains.”
- Assign responsibility for ongoing measurement of processes and outcomes.

Planning for Scale-up of Changes

Scale-up involves overcoming system and infrastructure issues that arise during implementation. For example, after pilot testing Teach Back, a hospital unit identified this as a successful improvement in patient learning. The hospital leadership then undertakes a deliberate implementation of this change in the whole hospital. The infrastructure required to sustain Teach Back on a unit may be different from the infrastructure required for implementation throughout the hospital (i.e., documentation in the electronic medical record or annual competency training). If there are barriers to scale up they should be noted and removed, if possible.

An important leadership consideration is whether staff have adequate time and resources to adopt the changes. Are the changes developed at the pilot level scalable to the entire

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organization? For example, using Teach Back for all patients may mean that nurses and other staff redesign activities and free up time to reliably implement this new competency.

Spreading Changes

Leaders should plan for spreading the improvement developed in the pilot population or unit during the early stages of the initiative. After successful implementation of the Key Changes, leaders develop a spread plan. Even though the changes have been tested and implemented, spread efforts benefit from testing and adaptation (using PDSA cycles) in new patient populations or organizations.

Successful spread of reliable processes requires leaders to commit sufficient resources to support spread. Pilot unit staff also play an important role in spread activities by 1) making the case that the changes contribute to better patient transitions and reduced readmissions, and 2) generating information and materials that leaders can package to ease spread. They may teach and mentor others.

A key responsibility of leaders is to develop a plan and timetable for spread and then to measure and monitor progress. Figure 33 shows an example of a tool to monitor spread of changes. This tool allows a leader to visualize spread progress of each change and the spread of changes across the locations.

Figure 33: Tool to Monitor Spread

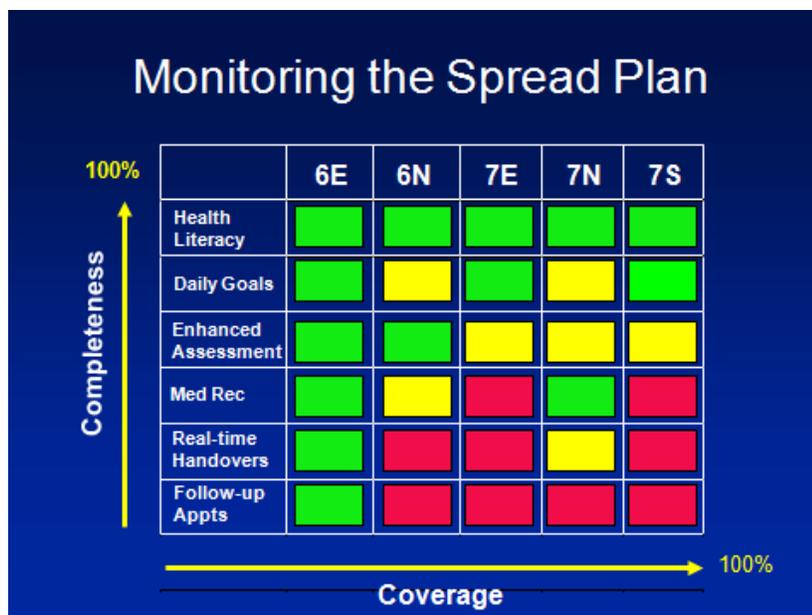


Figure 34: [Spread Tracker Template](#) (How-to Guide Resources, page 130)

<i>Spread Tracker Template</i>					
A=Planning B=Start C=In Progress D=Fully Implemented					
	Pilot Unit 1	Pilot Unit 2	Spread Unit 1	Spread Unit 2	Spread Unit
Change 1	D	C			

Leaders would want to determine if further guidance and support might accelerate progress and results. It is recommended that outcome measures be reported and tracked at the hospital or system level as well as at the unit level in order to provide leaders, unit managers, and front-line staff with regular feedback on their progress.

Books and articles:

Womack JP, Jones DT, Simon, Audio S. *Lean Thinking*. Simon & Schuster Audio; 1996.

Kenagy J. *Designed to Adapt: Leading Healthcare in Challenging Times*. Second River Healthcare Press, Bozeman MT; 2009.

Langley GJ, Moen R, Nolan KM, Nolan TW, Norman CL. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*: Jossey-Bass; 2009.

Massoud, MR, Nielsen, GA, Nolan, K., Schall, MW, Sevin, C. *A Framework for Spread: From Local Improvements to System-Wide Change*. IHI Innovation Series white paper. Institute for Healthcare Improvement; 2006. (Available on www.IHI.org)

Nolan KM, Schall MW (editors). *Spreading Improvement Across Your Health Care Organization*. Joint Commission Resources and the Institute for Healthcare Improvement; 2007:1-24.

Web tools and resources:

On Demand Presentation: An Introduction to the Model for Improvement. Institute for Healthcare Improvement. Available at:

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www.ihl.org/offerings/VirtualPrograms/OnDemand/ImprovementModelIntro/Pages/default.aspx.

Quality Improvement 101-106. *IHI Open School for Health Professions*. Available at www.ihl.org/offerings/IHIOpenSchool/Courses/Pages/default.aspx. The Institute for Healthcare Improvement offers online courses, through the IHI Open School for Health Professions, that are available free to medical students and residents and for a subscription fee for health care professionals.

V. Case Studies

Case Study 1: St. Luke's Hospital p. [69](#)

Case Study 2: University of California at San Francisco p. [78](#)

Case Study 1: St. Luke's Hospital (Cedar Rapids, Iowa)

In 2006 St. Luke's joined the IHI Transition to Home Collaborative. Prior to the IHI work, an improvement team focused on heart failure (HF) had been chartered (in 2001) and had already implemented the following:

- Standardized care through order sets;
- Patients identified via daily BNP reports;
- Outpatient heart failure education class; and
- Scheduling the follow-up physician office visit for patients before discharge.

Following the Collaborative kick-off, the team was expanded to include a home health care representative, a family member of a heart failure patient, a long-term/skilled care representative, and an outpatient physician clinic representative. This enhanced team, more broadly representing the patient's continuum of care, has played a major role in developing and testing changes to improve transitions out of the hospital for heart failure patients. The St. Luke's Patient and Family Advisory Council, formed in 2007, also provided valuable insight to the team in the design of the ideal transition to home.

The cross-continuum team continually makes improvements by aggregating the experiences of the patients, families, and caregivers. Readmissions are monitored and failures are reviewed by the cross-continuum team to assess opportunities for improvement.

Key Changes Implemented

1. Perform an Enhanced Assessment of Post-Hospital Needs

The patient care units conduct bedside reports to involve the patient and family caregivers as partners in the care. In addition, a daily discharge huddle is facilitated with the RN caring for the patient, the charge nurse, and unit-based case manager. Daily goals are reviewed and written on the whiteboards in each patient room, providing an opportunity to review the plan for the day, anticipate discharge needs, and determine what it will take to get the patient home safely. A section of the whiteboard is reserved for the patient or family to write questions for the care team. The whiteboard (24 in. x 36 in., see Figure 35 below) was developed by the Patient and Family Advisory Council and has been adopted by all medical/surgical areas.

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During the admission process, the patient is asked which family caregiver(s) they want to have present when discharge information is discussed. This information and the anticipated discharge date are both documented on the whiteboard to enhance the patient’s and family caregivers’ ability to plan for the transition to home.

Figure 35: Example of Patient Whiteboard, St. Luke's Hospital, Cedar Rapids, IA

Welcome To: Room Number: 408-B Phone #: 319-369-7561	
Patient Name: Please Call Me: One Thing You Should Know About Me: The Most Important Thing To Me During My Hospital Stay:	Today's Date: Anticipated Discharge Date: Plan and Goals For The Day: 
Health Care Team: Nurse: Tech: Doctors: Therapists:	Test - Treatments - Procedures: 
Diet: 	Pain Management Goal: Our Goal is to ALWAYS help control your pain!  My Pain Goal: <input type="text"/> My Last Pain Medication: <input type="text"/>
Activity: 	Family - Patient Comments: 
Safety Alerts/ Special Needs: 	Key Contact Person:
	Quiet Time 12:30 pm to 1:30 pm / 2:00 am to 4:00 am:  A better place to be Mission: To give the healthcare we'd like our loved ones to receive.

Key Learning to Date

The team at St. Luke’s Hospital learned that building relationships with their patients helped them to discover more critical information about patient and family caregiver needs and fears about going home. The hospital initiated a “Take 5” program, where nurses visit informally with the patient each day — to connect on a personal basis, thereby building a relationship to better discover needs, wants, fears, and barriers.

2. Provide Effective Teaching and Facilitate Enhanced Learning

The cross-continuum team revised the patient education processes and materials to incorporate health literacy concepts and to ensure that the same care instructions are given to patients, in a

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consistent manner, across the continuum of care: in the hospital, with the home health care agency, in long-term care settings, and in the heart failure clinic.

- Written materials were redesigned to incorporate plain language, appropriate use of color, and only the “need to know” concepts. The team solicited feedback from patients and family caregivers during the testing of draft materials as well as through focus groups, and with the outpatient heart failure class participants.
- Teach Back, the process of asking patients to recall and restate in their own words what they have been taught, was incorporated into the patient education standards at several key times: at the patient’s bedside during their hospital stay, during the 24- to 48-hour post-discharge follow-up visit by Home Health, and during the follow-up phone call to the patient seven days post-discharge.
- A yearly nurse competency validation on health literacy and Teach Back has been implemented. This includes role-playing on educating patients with structured observation and peer-to-peer critique on the key components of Teach Back: shame-free questioning, positive tone, plain language, and avoiding the phrase “do you understand.”

Specified Teach Back questions (the “need to know” elements) have been tested and implemented for heart failure and COPD and are being tested for other conditions. A patient teaching flowsheet is set up to address the use of Teach Back and documentation addresses the Teach Back results.

Patients with heart failure and their family caregivers are given a 12-month calendar at discharge (Figure 39). The calendar includes information and reminders on maintaining health, a designated space for tracking daily patient weight, and the dates of upcoming educational classes on heart failure for the patient and family.

Examples of St. Luke’s patient teaching tools follow.

- Heart Failure Magnet: To help patients remember the signs and symptoms that signal a need to contact their physicians and to ensure they know who to call (Figure 36)
- Heart Failure Zones: Gives patients and families a simple way to assess when they are in good shape or starting to decline (Figure 37)

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- Low Sodium Eating Plan: Patient-friendly instructions on how to use less salt as they plan their eating from day to day (Figure 38)
- Calendar: A place to document daily weights, with friendly reminders about seasonal challenges and the St. Luke’s HF class schedule (Figure 39)

Figure 36: [Heart Failure Magnet — St. Luke’s Hospital](#) (How-to Guide Resources, page 131)



Figure 37: [Heart Failure Zones — St. Luke’s Hospital](#) (How-to Guide Resources, page 132)

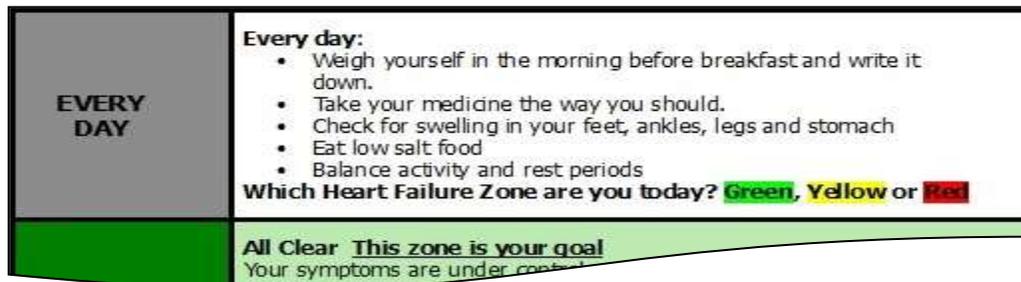


Figure 38: [Low Sodium Eating Plan — St. Luke’s Hospital](#) (How-to Guide Resources, page 133)

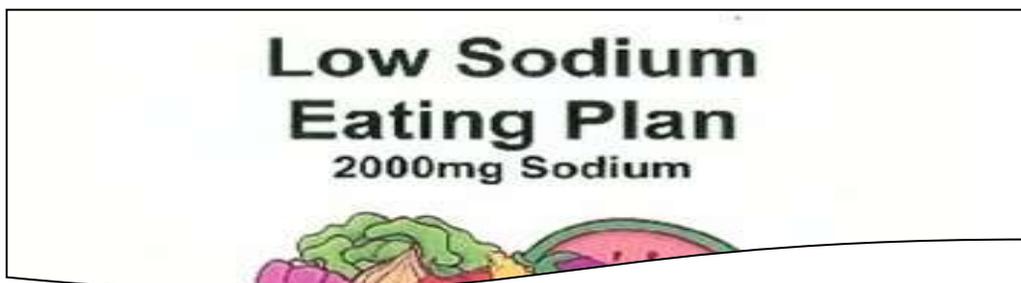
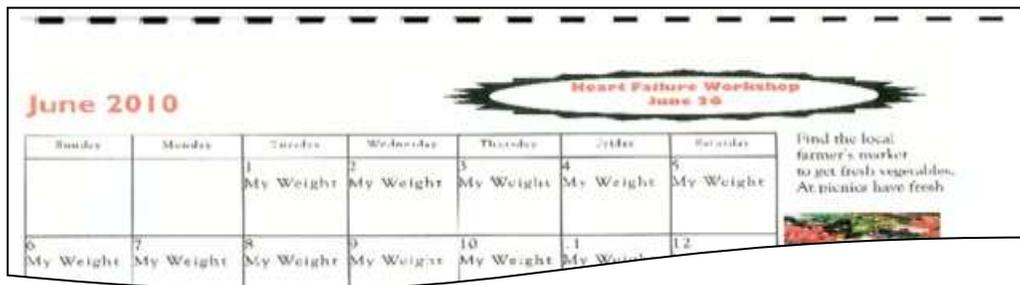


Figure 39: [Patient Calendar Example — St. Luke’s Hospital](#) (How-to Guide Resources, page 137)



Key Learning to Date

In 2008, the team noticed varying staff skills and reliability in use of Teach Back and added a yearly nurse competency validation on health literacy and Teach Back that includes a demonstration video and interactive role-playing on effective patient education. Staff read scenarios and role play with a second staff member, and then critique each other in effective, patient-centered techniques. In addition to the medical-condition-specific Teach Back questions, Teach Back is also encouraged as a technique in daily practice for checking patient understanding of things such as the use of call-lights, therapy treatments, and medications, and to assess the effectiveness of staff-to-staff communication. As more patient and family caregivers participated in helping redesign whiteboards, teaching materials, and patient education processes, team members saw the true benefits of including patients and family caregivers as partners in redesigning these materials and the transition processes.

3. Ensure Post-Hospital Care Follow-up

Partnership with physician offices resulted in redesign of scheduling post-discharge visits to allow office visits within three to five days for all HF patients. In 2007, the rate of adherence was 5 percent to 10 percent. Cases were reviewed with the physician groups to increase awareness of the need for the visit. The improvement was slow. The key was agreement on a standing order from the cardiology specialty groups and hospitalist for an appointment within three to five days after discharge. The local cardiology specialty group does provide a HF clinic. The APN works closely with these clinic nurses and communication flows in both directions to keep the team informed on patient needs.

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St. Luke's partnered with its home health care agency to provide complementary post-hospital home assessment within 24 to 48 hours after discharge to all patients with heart failure, regardless of whether they qualified for home health care. This process has benefited patients by providing greater support and education, including additional reinforcement and in-home assessment (e.g., medication reconciliation, adherence to self-care regimen, or need for further home health care services). Often during that home visit, the nurse can observe social support issues that were not as evident in the hospital. During the visits, the nurses use the same patient education tools from the hospital to verify patient understanding of self-care through Teach Back. The patient is asked where in the house their critical discharge information (such as the magnet, pictured above) is located. The home visits are paid for by a joint effort of the hospital and VNA, but patients often convert to a certified home visit when new needs are uncovered during the complementary visit. Tests of this process change began in November 2006 and were hardwired in January 2007. In 2010, approximately 75 percent of patients with heart failure discharged to home receive a home visit. About 11 percent of patients refuse the visits and some patients are still missed if they have a short stay over a weekend.

The APN sees the patient in the hospital and conducts a follow-up phone call seven to nine days post-discharge. During this call, the APN assesses satisfaction with the discharge instructions and also uses Teach Back to determine the patient and/or caregiver understanding of the critical self-care instructions.

Key Learning to Date

By the end of the first year of work, the cross-continuum team became a powerful force in building cross-setting relationships, facilitating focus on common aims and values for all parties and making a difference for patients and families.

4. Provide Customized Communications to Community Care Providers, Patients, and Family Caregivers

St. Luke's partnered with the hospital's home health care agency (VNA) and two long-term care facilities to standardize and enhance the quality of the handoff communication process, including co-designing the interagency transfer form to meet both the sender's (hospital) and receiver's (next site of care) needs. St. Luke's provides education to long-term and skilled care nurses, as well as to the certified nursing assistants (CNAs), on heart failure and the transition to home process. The CNA education has proved especially important since they may observe patient symptoms in the facilities and are often responsible for weighing patients.

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Medication reconciliation is a joint physician and nurse responsibility. The physician is provided with a report at discharge to reconcile the home medication list with medications prescribed while the patient was in the hospital. The nurse puts the reconciled medication list in the patient's discharge instructions. A second nurse double-checks, comparing the orders to the discharge instructions.

In August 2007, review of readmitted patients helped staff realize the need for referral to palliative care for patients with advanced stages of disease. Criteria for referral continue to be tested, but initial changes have increased referrals from less than 5 percent to over 20 percent. A full-time physician, social worker, and nurses have been added to the program. Discussions between the medical director of palliative care and attending physicians have enhanced their understanding of the program and potential benefits to patients. In late 2008, an advanced practice nurse (APN) for the outpatient setting was added to the palliative care program in response to many requests for assistance with palliative care discussions with patients in the physician offices.

Key Learning to Date

Palliative care services in the hospital and community are needed by a higher percentage of patients than previously understood before embarking on improving the transition processes. The work requires an intense and explicit focus on patient- and family-centered care, and a keen awareness of the home environment.

Barriers Encountered

- Criteria for certifying patients for home health care services are problematic. Some patients refuse the needed support because they fear being “homebound.” Support in the home can easily unravel and patient status can quickly deteriorate. Having home health care staff visit the home in the first 24 to 48 hours after discharge can provide the needed support to prevent a readmission.
- Physician clinic access can impact the ability to schedule a follow-up appointment three to five days after discharge. Working with the clinic to allow for some open appointments is important.

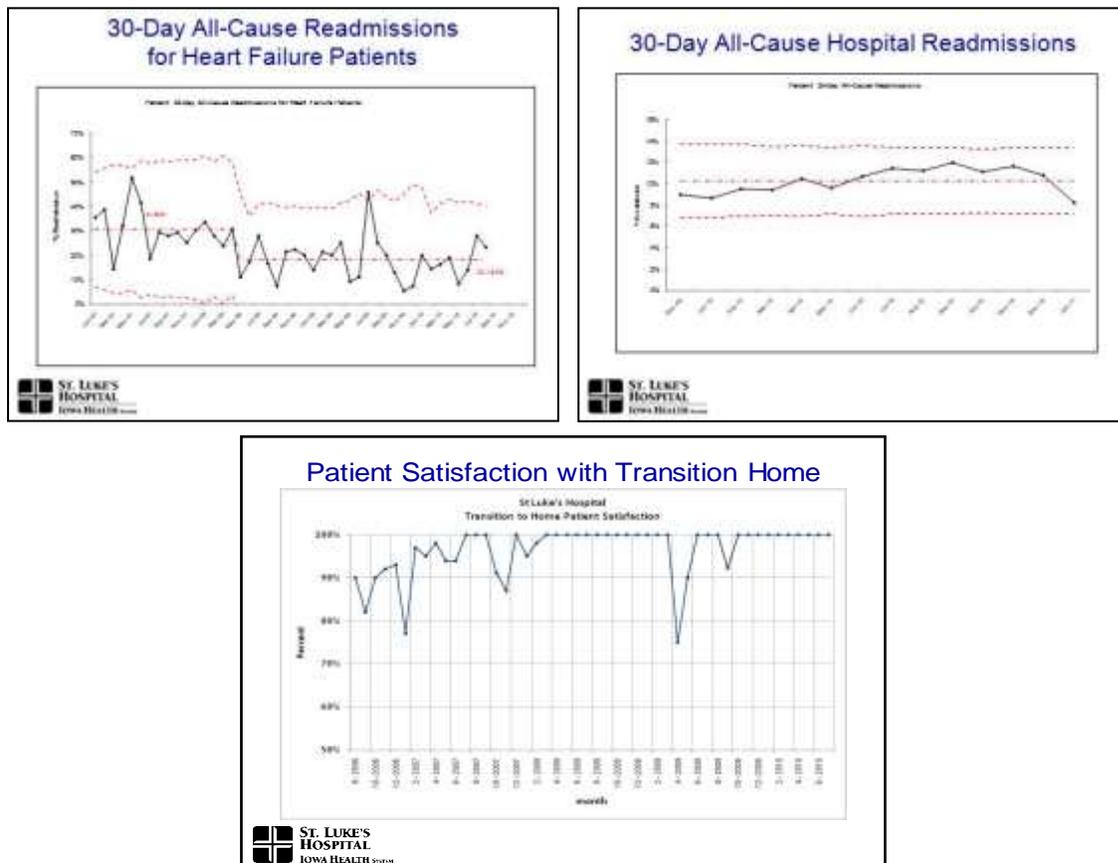
Breakthroughs and Key Lessons Learned

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- Leadership engagement and support is essential.
- Participation in the early IHI TCAB initiative made a difference.
- This work has to be done in tandem with compliance to Centers for Medicare & Medicaid Services (CMS) Core Measures.
- Patients and family caregivers help transform care in profound and unexpected ways.
- Involving the front-line staff in the changes helps them understand why it is important and grows ownership by engaging them in redesign.
- Ongoing monitoring of processes is important to hardwiring the best practices.
- Ongoing data provided by the Quality Department helps drive the work.
- Using patient stories unleashes energy and participation that becomes evident in process and outcome results.

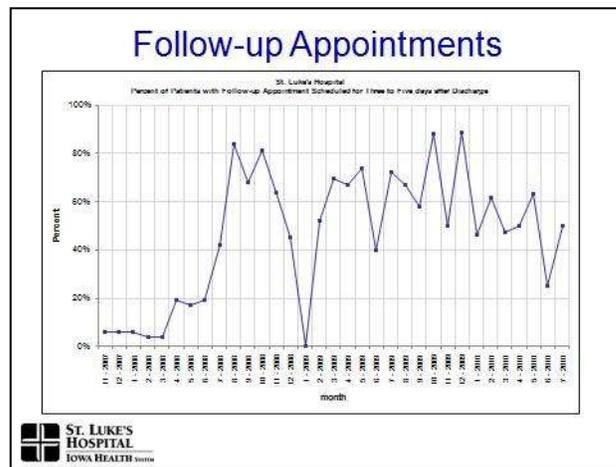
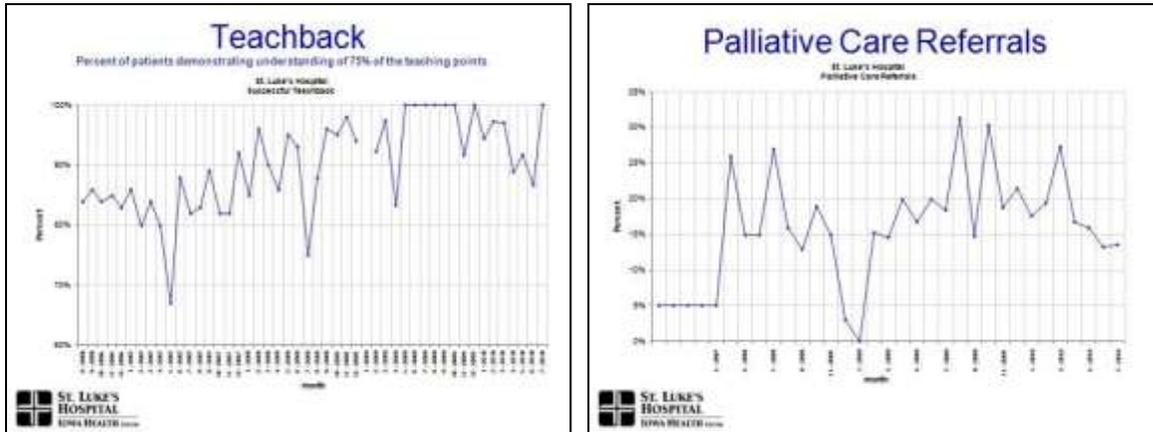
Results: Outcome Measures

Figure 40: Results: Outcome Measures



Results: Process Measures

Figure 41: Results: Process Measures



Additional Reading: [Improvements in Care Transitions: A Case Study of St. Luke's Hospital.](#) 50

Case Study 2: University of California at San Franciscoⁱ

In October 2008, with funding from the Gordon and Betty Moore Foundation, the University of California at San Francisco (UCSF) joined with IHI and three other San Francisco Bay Area hospitals to reduce 30-day and 90-day readmissions for elderly heart failure patients. Starting off as participants in IHI's Transforming Care at the Bedside initiative, clinicians and staff at UCSF worked to test, implement, and spread four key changes for creating an ideal transition home.

In addition to the technical assistance from IHI, UCSF received funding from the Moore Foundation for two part-time heart failure nurses to coordinate a disease management program. Their initial focus was on discharge planning, but quickly expanded to include care coordination across the continuum. These UCSF team leaders paid particular attention to communication — they identified the key stakeholders across the system and met with each of them to explain the program and its goals; they wrote and distributed weekly newsletters to share stories and information about their progress; and they reached outside of the hospital to share information and ideas with cross-continuum providers such as home health care agencies, skilled nursing facilities, and primary care physicians. The team believes that this unwavering commitment to sharing information, telling stories, and understanding the role of the whole system in keeping patients safe at home has been instrumental to their success.

The UCSF senior leadership has additionally supported the HF program by starting a Heart Failure Readmissions Task Force led by Associate Chief Medical Officer, Adrienne Green, MD, and Director of Quality Improvement and Regulatory Affairs, Brigid Ide, RN, MS. This task force tracks various metrics, identifies and assists with barriers, and facilitates system changes to improve care for patients throughout UCSF.

Key Changes Implemented

1. Perform an Enhanced Assessment of Post-Hospital Needs

Nurses complete admission assessment with patients and families within 24 hours of admission; primary care physicians and other members of the care team are notified of the admission; pharmacists and physicians reconcile medications upon admission; and referrals for smoking

ⁱ While UCSF is not a participant in the STAAR initiative, this case study represents results that were achieved by implementing IHI's recommended changes in an academic medical center.

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cessation counseling, case management, social services, and dietary consultations are initiated when indicated.

Key Learning to Date

About a year into the project, the team at UCSF began to realize that the enhanced assessments were not being reliably completed. They assumed that since admission assessments were already a part of the existing process that the assessments were being completed, but when they looked at the data they found that about one-third of their patients were not being adequately assessed within 24 hours. This prompted the team to investigate why and, using an anonymous survey tool, they harvested information from nurses on the barriers to prompt completion of assessments and uncovered actionable issues. This information was shared with leadership and a separate task force was chartered to address the barriers. Since bigger solutions would take time, the problems led them to think about focusing on the specific needs of their high-risk patients — to make the key components of assessment reliable for them. For example, they realized that, in particular, failure to assess promptly was resulting in delayed consults for dietary consultations and for physical or occupational therapy.

2. Provide Effective Teaching and Facilitate Enhanced Learning

The heart failure nurses assessed and redesigned their patient education materials and processes in accordance with health literacy principles. Materials were reviewed by a select group of cardiologists, hospitalists, dietitians, and a geriatric clinical nurse specialist (CNS) and included a general overview of heart failure, heart failure zones, a guide to living with heart failure, a low salt eating plan, daily weight charts, fluid restriction, and information on falls prevention. Four essential HF teaching documents are available on the UCSF Patient and Family Education website for anyone to order — in four different languages.

Patients are given a Heart Failure Discharge Binder with thorough (and patient-friendly) education on HF disease, medications, and self-management (including weight charts and nutrition labels). Materials are customized for each patient with the name and phone number of the physician to call with questions and for follow-up care, and patients are coached on how to talk to physicians when they are having symptoms that need attention.

The heart failure nurses identify the primary learners on admission and ensure that the learners have the right information about the patient's post-discharge needs; Teach Back is used during

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the inpatient stay and during outpatient follow-up calls to assess patient and family understanding of discharge instructions and the ability to perform self-care.

To institute Teach Back as a standard of care, the HF nurses started by training and educating nurses on three pilot units to use Teach Back in their daily work. They then taught home health care nurses, SNF staff, and others about the Teach Back technique and its benefits and recruited three to four Teach Back “champions” on each unit to help train and resource the Teach Back technique for staff nurses. Once they felt confident that the technique could be broadly adapted across the institution, they developed specific competencies for staff nurses in the Teach Back technique.

Key Learning to Date

Shifting the focus of education from what nurses and other educators were teaching to what patients were learning has been transformative for the hospital. It quickly became clear that this change was ripe for spreading across the hospital for the care of all patients, not just heart failure patients.

The team leaders found that the educational materials needed a complete overhaul. They brought in multidisciplinary partners (physicians, pharmacists, dieticians) to make sure materials met everyone’s needs (staff, patients and families, and others). For example, patients needed information on which physician to call and for what, which led the team to incorporate doctors’ names and phone numbers within the educational materials. Patients also need coaching on how to talk to physicians when they are in the “yellow zone,” so scripts were developed and included in the educational packets. The materials revisions took months, but the team was very pleased with the results.

3. Ensure Post-Hospital Care Follow-up

To ensure appropriate post-acute follow-up care, the primary care team schedules a follow-up appointment (within seven days of discharge) with the assistance of the scheduler; the Case Manager prompts home health care orders from the primary care team; and the HF nurse verifies the follow-up appointment and home health care orders prior to discharge. (Home health care referrals have increased from about 51 percent in 2009 to about 73 percent at the end of 2010 into the beginning of 2011.)

The HF nurses call patients that have been discharged to home within three to five days after discharge, and again within 30 days after discharge. On the first follow-up call, the patient is

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asked if they were discharged with a follow-up appointment and, if so, the date of the appointment.

In August 2010, UCSF launched GeriTraCCC, a new service designed to provide transitional care to older heart failure patients at risk for post-discharge complications. GeriTraCCC provides post-discharge house calls and works with the home health nurses and with each member of the team to smooth the patient's transition and facilitate care of geriatric issues which may be impeding his or her optimal care at home. Criteria for referral include:

- Prior admission within six months;
- Scheduled follow-up appointment that was missed or unable to attend;
- Cognitive concerns;
- Caregiver adequacy concerns;
- Complicated change in medications; and
- Seen by inpatient Palliative Care Service or needing post-discharge palliative care follow-up for symptom management or goals of care.

Key Learning to Date

An early “a-ha” moment came when the team realized that while a scheduler was routinely making follow-up appointments for patients before discharge, no system was in place to inform those patients that appointments had been made. This led to a better understanding of information flow across the system.

4. Provide Real-Time Handover Communications

Each service is working to improve communication with outside providers. Health Information Services does audits each quarter and reviews a number of patient records to see if discharge summaries were complete within 14 days. BOOST hospitalists are working on an electronic discharge summary form that will help solve medication and other issues with outpatient providers. The HF nurses email the inpatient team, case manager, and UCSF primary care physician to notify that their patient is being followed by the UCSF Heart Failure Program on admission, and they continue to communicate with this team about issues and concerns that surface during the hospital stay and on follow-up calls with patients. On discharge, a sticker with

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an easily identifiable logo is placed on the transition record for heart failure patients, with the names and contact information for the HF nurses.

Medication reconciliation is completed by pharmacists and the bedside nurse at the time of discharge. Work is underway to pilot test a new patient-friendly medication card.

Key Learning to Date

Given the opportunity, care teams have lots of information to share with one another. The team leaders started notifying patients' care teams (attending physicians and residents, primary care team, specialists, and case managers) about the Heart Failure Program's services to their patients. This has resulted in important patient information being shared across the team (for example, issues around expectations on who was managing a patient's psychiatric medications).

Lack of communication is the source of many problems that lead to readmissions. Home health care and SNFs welcome opportunities to improve handoff communication, share materials, and change practice in support of better patient care. When it became clear that these providers didn't always know which patients were in the UCSF Heart Failure Program, the team devised a sticker with an easily identifiable logo that is placed on the transition record and includes the HF nurses' names and contact information.

5. Improve Connections to the Palliative Care Program

As the team began looking more deeply into data on frequently readmitted patients, they realized that there were few opportunities for very sick HF patients to have the difficult discussions with their doctors about goals of care. The team connected with UCSF's well-established palliative care program, which had been used primarily for oncology patients, and worked with that team to expand services to HF patients and their families. The team leaders are now certified trainers in end-of-life nursing education, helping them effectively support more goals of care and end-of-life discussions.

6. Collaborate with Post-Hospital Community Providers (HF clinics, primary care physicians, home health care agencies, and skilled nursing facilities)

The UCSF team found that their colleagues receiving patients into the next site of care (particularly SNF and home health care) were thrilled to coordinate and cooperate on reducing

readmissions. They shared educational materials and the UCSF team provided in-services on HF to their colleagues, both of which were very well received.

7. Provide Supplemental Discharge Teaching

Through close connections with their patients and observations of individual needs and trends, the UCSF team continually identified new ways to help patients stay safely at home, including:

- Education on falls prevention;
- Brochures on spiritual care and palliative care;
- Letter summarizes patient status updates to primary care physician; and
- Patient script for calling the doctor for symptoms in the “yellow warning zone” (to help patients communicate about warning signals to their physicians).

Barriers Encountered

- Different systems on different units: The team initiated standardized systems for HF Program patients (heart failure folders, discharge checklist, whiteboards in patient rooms, daily weights, sticker on transition record).
- Misconception of palliative care: Physicians were reluctant to order palliative care consults (which is often thought of as a request for hospice care); through continued education, the palliative care team consults have increased.
- Follow-up appointments: It is often difficult to schedule a follow-up appointment within one week of discharge; now the team is promoting follow-up appointments with primary care physicians and have seen improvement. High-risk patients are now able to schedule an appointment with a nurse practitioner in the clinic immediately post-discharge.
- Discharge process: The redesigned discharge process aimed to address unreliable processes for medication reconciliation, lack of coordinated communications, and variability of processes on units, and now also includes utilization of Teach Back and guidance for ordering consults and services needed.

Breakthroughs and Key Lessons Learned

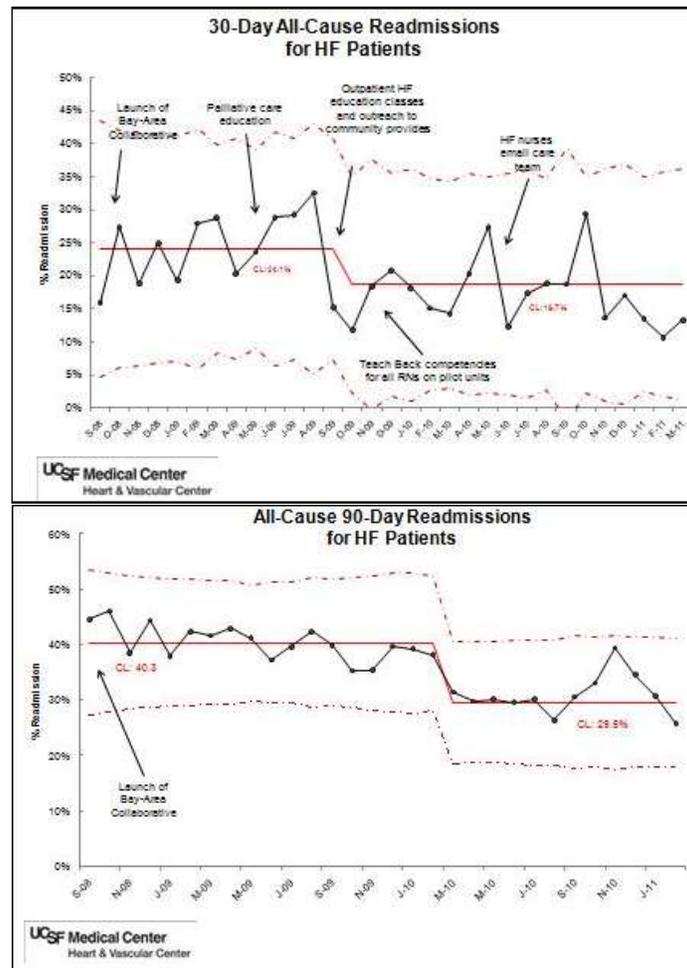
- Collaboration with IHI provided an essential start and guidance throughout the process

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- Building a relationship and trust is key — and it takes time; patients with HF and other chronic diseases require more than simply teaching (must get patient “buy-in”)
- Importance of palliative care and goals of care discussions
- Power of the *patient story* to learn from and drive change
- Results are not immediate; it takes time to show improvement
- Teach Back works; a focus on health literacy is necessary
- Senior leadership support is essential
- Communication, communication, communication

Results: Outcome Measures

Figure 42: Results: Outcome Measures

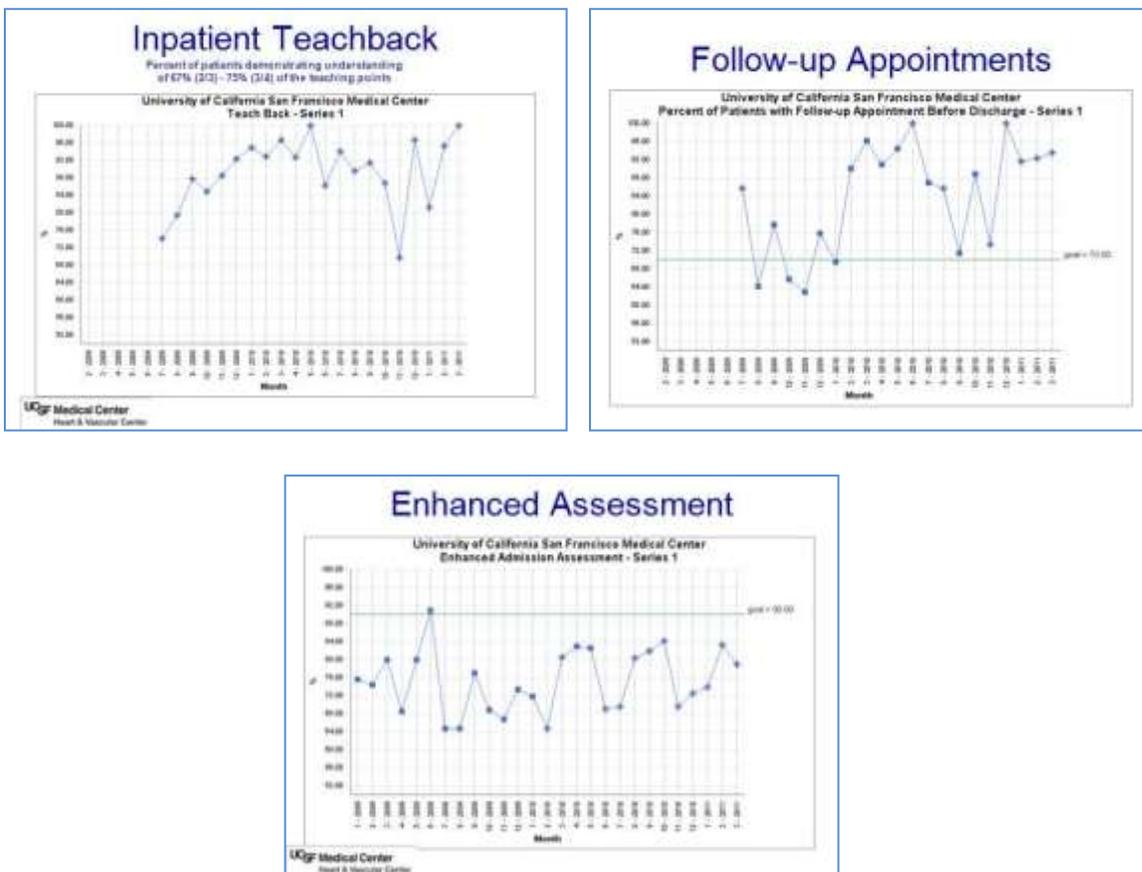


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For UCSF heart failure patients, 30-day all-cause readmissions have declined since the launch of this initiative, from about 24 percent in 2009 to about 19 percent in 2010, and continue to decline towards the current goal of 16 percent or less. This data suggests that the team averted approximately 41 admissions in calendar year 2010. In an analysis of the financial impact to Medicare for reducing 30-day readmissions, if UCSF maintained a 16 percent readmission rate it would mean a savings of approximately \$1 million annually for Medicare.

Results: Process Measures

Figure 43: Results: Process Measures



VI. System Measures

Outcome Measures: Readmissions				
Measure	Description	Numerator	Denominator	Data Collection Strategy
30-Day All-Cause Readmissions	Percent of discharges with readmission for any cause within 30 days	Number of discharges with readmission for any cause within 30 days of discharge Exclusion: Planned readmissions (e.g., chemotherapy schedule, rehab, planned surgery)	The number of discharges in the month Exclusions: Labor and Delivery, transfers to another acute care hospital, patients who die before discharge	Write a report to run no sooner than 31 days after the end of the measurement month. This report will: 1a. Pull all the discharges in the measurement month 1b. Remove exclusions (transfers to other acute care, deceased before discharge, Labor and Delivery) The number of discharges after you remove the exclusions is your denominator (or “index discharges”). 2a. Through the unique medical record identifier, identify those (index) discharges that resulted in readmissions within 30 days of the discharge 2b. Remove exclusions (planned readmissions like chemotherapy, radiation, rehab, planned surgery, renal dialysis) The number of (index) discharges that resulted in readmissions within 30 days will be your numerator.
Readmissions Count	Number of readmissions (numerator for % readmissions)	N/A	N/A	Use the numerator specified in the measure above
30-Day All-Cause Readmissions for a Specific Clinical Condition	Percent of discharges with a specific clinical condition readmitted for any cause within 30 days of discharge	Number of discharges with a specific clinical condition readmitted for any cause within 30 days of discharge Exclusion: Planned readmissions (e.g., chemotherapy schedule, rehab, planned surgery)	Number of discharges in the month with the specific clinical condition Exclusions: Labor and Delivery, transfers to another acute care hospital, patients who die before discharge	<i>See above</i>

Outcome Measures: Patient Experience				
Measure	Description	Numerator	Denominator	Data Collection Strategy
HCAHPS Discharge Question 19 (Q19)	“Did hospital staff talk with you about whether you would have the help you needed when you left the hospital?”	Number patients surveyed in the month who answered, “yes”	Number of surveys completed in the month for the hospital with an answer for this question	
HCAHPS Discharge Question 20 (Q20)	“Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?”	Number patients surveyed in the month who answered, “yes”	Number of surveys completed in the month for the hospital with an answer for this question	
Patient Experience: Care Transitions Measures (Pilot unit data) (CTM3) <i>This measure is taken from Dr. Coleman’s Care Transitions ProgramSM:</i> www.caretransitions.org	Three questions asked on follow-up phone call: 1) The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital. 2) When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. 3) When I left the hospital, I clearly understood the purpose for taking each of my medications.	Calculate the sum of responses across the 3 items. Responses are scored: Strongly Disagree = 1 Disagree = 2 Agree = 3 Strongly Agree = 4	Number of questions answered across all patients asked	Collect data on routine follow-up phone calls. Sample 20 patients: If you have less than 20 discharges per month, report 100%. Response options: Strongly Disagree, Disagree, Agree, Strongly Agree, or Don’t Know/Don’t Remember/Not Applicable Do not count in your denominator questions where the patient responded don’t know/remember or not applicable. If disagree, ask (and document) what their concerns were.

Balancing Measures				
Measure	Description	Numerator	Denominator	Data Collection Strategy
30-Day All-Cause Readmission to Observation Status	Percent of patients readmitted to observation status within 30 days of a hospital discharge	Number of discharges with readmission to observation status for any cause within 30 days of discharge	The number of discharges in the month Exclusions: Labor and Delivery, transfers to another acute care hospital, patients who die before discharge	Write a report to run no sooner than 31 days after the end of the measurement month. This report will: 1a. Pull all the discharges in the measurement month 1b. Remove exclusions (transfers to other acute care, deceased before discharge, Labor and Delivery) The number of discharges after you remove the exclusions is your denominator (or “index discharges”). 2. Through the unique medical record identifier, identify those (index) discharges that resulted in admission to observation status within 30 days of the discharge The number of (index) discharges that resulted in observation status admission within 30 days will be your numerator.
Count of Observation Admissions within 30 Days of Hospital Discharge	Number of patients admitted to observation status within 30 days of a hospital discharge	Number of discharges with readmission to observation status for any cause within 30 days of discharge	NA	Use the numerator specified in the measure above

Balancing Measures				
Measure	Description	Numerator	Denominator	Data Collection Strategy
Emergency Room Visits within 30 Days of Hospital Discharge	Percentage of patients who have ED Visit within 30 days of hospital discharge	Number of patients with ED visit within 30 days of hospital discharge	The number of discharges in the month Exclusions: Labor and Delivery, transfers to another acute care hospital, patients who die before discharge	Write a report to run no sooner than 31 days after the end of the measurement month. This report will: 1a. Pull all the discharges in the measurement month 1b. Remove exclusions (transfers to other acute care, deceased before discharge, Labor and Delivery) The number of discharges after you remove the exclusions is your denominator (or “index discharges”). 2. Through the unique medical record identifier, identify those (index) discharges that resulted in an ER Visit within 30 days of the discharge The number of (index) discharges that resulted in ER visits within 30 days will be your numerator.

Process Measures				
Measure	Description	Numerator	Denominator	Data Collection Strategy
<p>Patient and Family Involvement in Early Assessment for Post-Discharge Needs</p> <p>Measure: Percent of admissions where patients and family caregivers are included in assessing post-discharge needs</p>	<p>“Family” is defined by the patient and includes any individual(s) who provide support. “Family caregivers” is the phrase used to represent those family members who are directly involved in care of the patient outside the hospital or other community institutions.</p> <p>Consider asking patients and families a set of (open-ended) questions — feel free to adopt, adapt, or abandon those suggested below:</p> <ul style="list-style-type: none"> • <i>How do you think you became sick enough to come to the hospital?</i> • <i>How do you take your medicines and set up your pills each day?</i> • <i>Describe your typical meals at home.</i> • <i>What are your biggest concerns for the post-hospital period?</i> 	<p>Number of admissions in sample where patients and families were included in assessing post-discharge needs</p>	<p>Number of admissions in the sample</p>	<ul style="list-style-type: none"> • Option 1: Review charts of 10 to 20 patients discharged from the pilot unit: 2 to 5 per week for 4 weeks a month • Option 2: Build data collection into discharge process – i.e., at discharge, review record to determine if patients and families were included in an assessment for post-discharge needs <p>Enter data monthly</p>
<p>Patient Teach Back</p> <p>Measure: Percent of observations of nurses teaching patients or other identified learner where Teach Back is used to assess understanding</p>	<p>Percent of observations of nurses teaching patient or other identified learner where Teach Back is used to assess understanding</p> <p>This data can be measured for other disciplines (e.g., physician, dietary, pharmacy, etc.) as necessary.</p>	<p>Number of observations of nurses where Teach Back is used to assess understanding</p>	<p>Number of observations of nurses teaching</p>	<p>Observe 10 to 20 teaching opportunities from the pilot unit: 2 to 5 per week for 4 weeks a month</p> <p>Enter data monthly</p>

Process Measures				
Measure	Description	Numerator	Denominator	Data Collection Strategy
<p>Timely Handover Communication</p> <p>Measure: 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)</p>	<p>Decide in advance what “critical information” should be included in the real-time transfer information. The Transitions of Care Consensus Policy Statement suggests the following:</p> <ul style="list-style-type: none"> • Principle diagnosis and problem list. • Medication list (reconciliation), including over-the-counter medications/herbals, allergies, and drug interactions • Clear identification of the medical home, transferring coordinating physician/institution, and the contact information • Patient’s cognitive status • Test results/pending results 	<p>Number of patients in the sample where 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)</p>	<p>Number of patients in the sample</p>	<ul style="list-style-type: none"> • Option 1: Review charts of 10 to 20 patients discharged from the pilot unit: 2 to 5 per week for 4 weeks a month • Option 2: Build data collection into discharge process – for example, collect copies of the transfer forms and count them up, or keep a tally sheet <p>Enter data monthly</p>
<p>Patient-Friendly Post-Hospital Care Plan</p> <p>Measure: Percent of patients discharged who receive a customized post-hospital care plan written in patient-friendly language at the time of discharge</p>		<p>Number of patients in the sample who receive a customized post-hospital care plan written in patient-friendly language at the time of discharge</p>	<p>Number of patients in the sample</p>	<ul style="list-style-type: none"> • Option 1: Review charts of 10 to 20 patients discharged from the pilot unit: 2 to 5 per week for 4 weeks a month • Option 2: Build data collection into discharge process – for example collect copies of the care plans and count them up, or keep a tally sheet. <p>Enter data monthly</p>

Process Measures				
Measure	Description	Numerator	Denominator	Data Collection Strategy
<p>Post-Hospital Care Follow-up</p> <p>Measure: Percent of patients discharged who had a follow-up visit <u>scheduled</u> before being discharged in accordance with their level of assessed risk</p>		<p>Number of patients in the sample who had a follow-up visit <u>scheduled</u> before being discharged in accordance with their level of assessed risk</p>	<p>Number of patients in the sample</p>	<ul style="list-style-type: none"> Option 1: Review charts of 10 to 20 patients discharged from the pilot unit: 2 to 5 per week for 4 weeks a month Option 2: Build data collection into discharge process – i.e., at discharge, review record to determine if appointments were made in accordance with risk assessment <p>Enter data monthly</p>

VI. How-to Guide Resources

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Going Home: What You Need to Know	p. 96	p. 14
Observation Guide: Observing Current Processes for Patient Teaching	p. 99	p. 17
Key Educational Topics for High-Volume Clinical Conditions	p. 101	p. 19
Teach Back Competency Validation	p. 103	p. 22
Observation Guide: Observing Current Discharge Processes	p. 106	p. 33
How to Create a Pill Card	p. 108	p. 35
User-Friendly Medication Card	p. 108	p. 35
Taking Care of Myself: A Guide for When I Leave the Hospital	p. 109	p. 36
BOOST Patient PASS: A Transition Record	p. 112	p. 37
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Puget Sound Heart Failure Care Transition Summary Form	p. 115	p. 40
Akron Regional Hospital Association Post-Acute Transfer Form	p. 116	p. 40
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Heart Failure Zones – St. Luke’s Hospital	p. 132	p. 72
Low Sodium Eating Plan – St. Luke’s Hospital	p. 133	p. 72
Patient Calendar Example – St. Luke’s Hospital	p. 137	p. 73

Observation Guide: Observing Current Processes for an Admission Assessment

Observe three admission assessments as they are currently done by nurses and physicians. Reflect on what you observed to discover what went well and where there are opportunities for improvement.

What do you predict you will observe?

Did the care team member(s)...	Patient # 1		Patient # 2		Patient # 3	
	Yes	No	Yes	No	Yes	No
Ask patients and family members about the contributing factors for this admission?	<input type="checkbox"/>					
Ask community caregivers about their assessment of the patient and home-going needs?	<input type="checkbox"/>					
Ask if there were "family" caregivers who should be involved in discharge planning and education regarding the plan for home health care or care in a community setting?	<input type="checkbox"/>					
Complete the medication reconciliation processes?	<input type="checkbox"/>					
Assess the patient's cognitive and psychological status?	<input type="checkbox"/>					
Assess the patient's current functional status?	<input type="checkbox"/>					
Assess the patient's values, needs, and preferences?	<input type="checkbox"/>					
Assess the format in which patient and family caregivers learn best (e.g., written material, verbal discussion, video)?	<input type="checkbox"/>					
Assess the patient's ability to pay for medications and supplies or equipment?	<input type="checkbox"/>					
Assess the patient's ability to perform self-care and monitor health status (e.g., weight, blood pressure, blood glucose levels, etc.)?	<input type="checkbox"/>					
Create an individualized plan of care based on the assessment of the patient's needs for the post-acute care?	<input type="checkbox"/>					

Observation Guide: Observing Current Processes for an Admission Assessment

Reflections after observations are completed (to be shared with the entire team):

What did you learn?

How did your observations compare to the predictions?

What, if anything, surprised you?

What new questions do you have? What are you curious about?

What assumptions about patient education that you held previously are now challenged?

As a result of the findings from these observations, what do you plan to test?

- 1.
- 2.
- 3.
- 4.
- 5.

Going Home: What You Need to Know

Admission

Date of admission _____

Reason for admission _____

What was done during this hospital stay:

 Testing and monitoring Surgery Rehabilitation Other _____

Discharge

Date patient will be discharged _____

Diagnosis at discharge _____

Medications at discharge (you can use the medication form to help you organize the list of medication your family member is prescribed upon discharge)

Does the patient need to have someone accompany him or her home? Yes No

If yes, who will that person be? _____

How will the patient get home?

 Private car / taxi Public transportation (such as subway or bus) Paratransit (such as Access-a-Ride) Ambulance Other _____Are plans made for this transportation? Yes No

If yes, date and time of transportation: _____

Cost: _____

Services and Supplies

Medical Equipment

Does the patient need special medical equipment or supplies? Yes No

If yes, what type of medical equipment? (Check all that apply)

 Cane Colostomy care supplies Wheelchair Oxygen Hospital bed IV setup Walker Respirator Other (such as diapers or disposable gloves)Was this medical equipment ordered? Yes No

If yes, from where? _____

Telephone number: _____

Plans for delivery: _____

Special instructions: _____

Other notes (rental, co-pay, delivery): _____

Home Care Services

Is the patient being referred for home care services? Yes No

If yes, what type? (Check all that apply)

 Nursing (for medical tasks like wound care) Physical therapy (PT) Occupational therapy (OT) Speech therapy Home health aide (attendant) Other (such as Meals on Wheels) _____

Name of home care agency: _____

Telephone number: _____

Date and time of first visit: _____

Reason for this visit: _____

Follow Up

Special Foods and Diet

Does the patient need any special foods or diet? Yes No

If yes, what foods or diet? _____

Are there limitations on activity, such as bathing or lifting heavy items? Yes No

If yes, what are these limitations? _____

Notes and questions: _____

Medical Tests

Did the patient have any medical tests (for example, CT-scan, X-rays, blood or urine tests) for which you don't have results? Yes No

If yes, what are these tests? _____

Test 1. When should this test result be ready? _____

Who should I call for the result? _____

Test 2. When should this test result be ready? _____

Who should I call for the result? _____

If there are more tests for which you do not have results, please attach a separate sheet with the information as shown above.

Appointments

Does the patient have any follow-up appointments outside the home? Yes No

If yes, please answer these questions for each appointment:

1. Follow-up appointment

Who is the appointment with? _____

What is the reason for this appointment? _____

What date is the appointment? _____

What time is the appointment? _____

Where is the appointment? _____

Telephone number for the appointment: _____

How will the patient get to the appointment (transportation)? _____

Notes and questions: _____

2. Follow-up appointment

Who is the appointment with? _____

What is the reason for this appointment? _____

What date is the appointment? _____

What time is the appointment? _____

Where is the appointment? _____

Telephone number for the appointment: _____

How will the patient get to the appointment (transportation)? _____

Notes and questions: _____

If there are more follow up appointments, please attach a separate sheet with the information as shown above.

Observation Guide: Observing Current Processes for Patient Teaching

Observe patient teaching as it exists today. Observe three teaching sessions (done in the usual way) conducted by nurses or physicians. Reflect on what you observed to discover what went well and where there are opportunities for improvement.

What do you predict you will observe?

Did the care team member(s)....	Patient # 1		Patient # 2		Patient # 3	
	Yes	No	Yes	No	Yes	No
Use simple language and terminology?	<input type="checkbox"/>					
Use patient-friendly teaching materials?	<input type="checkbox"/>					
Request the patient Teach Back what was understood in the patient's own words?	<input type="checkbox"/>					
Use non-shaming language in the Teach Back request?	<input type="checkbox"/>					
Display a warm attitude?	<input type="checkbox"/>					
Use a friendly tone of voice?	<input type="checkbox"/>					
Display comfortable body language?	<input type="checkbox"/>					
Ask "Do you understand?" or "Do you have any questions? (THEY SHOULD NOT)"	<input type="checkbox"/>					
Use teaching materials in the patient's language of choice?	<input type="checkbox"/>					

Observation Guide: Observing Current Processes for Patient Teaching

Reflections after observations are completed (to be shared with the entire team):

What did you learn?

How did your observations compare to the predictions?

What, if anything, surprised you?

What new questions do you have? What are you curious about?

What assumptions about patient education that you held previously are now challenged?

As a result of the findings from these observations, what do you plan to test?

- 1.

- 2.

- 3.

- 4.

Key Educational Topics for High-Volume Clinical Conditions

St. Luke's Hospital, Cedar Rapids, Iowa, 2011

Pick an educational topic to teach your patient/family. Narrow it down to four or more teaching points: the “must haves” or “vital few” for the patient/family to know when discharged.

Generic	Heart Failure	COPD	Stroke	Chronic Kidney Disease	Mental Health
<p>Patient should explain diagnosis and health problems for which they need care.</p> <ul style="list-style-type: none"> • General understanding of disease process and self-care • Identify reason for hospitalization and current medical diagnosis 	<p>How would you explain heart failure to your family?</p>	<p>Tell me what you know about your COPD.</p>	<p>Do you know what happens when you have a stroke?</p>	<p>What do you need to do every day when you get home?</p> <ul style="list-style-type: none"> • Monitor B/P • Weigh daily – in the morning before breakfast; compare to yesterday's weight • Eat a balanced diet; monitor and limit your intake of protein, salt, and sugar • Reduce or stop drinking alcohol • Eat low-salt food • Balance activity with rest periods 	<p>Tell me how you would describe your condition to someone.</p>
<p>Patient should explain danger signs — what signs and symptoms to watch for. Who would you call if...?</p>	<p>What symptoms would you report to your doctor?</p>	<p>Which signs or symptoms should you watch for?</p> <ul style="list-style-type: none"> • Wheezing and coughing more than normal • Increase and more shortness of breath than normal • Changes in phlegm (color, texture, or amount) • Using rescue inhaler or inhaler more than normal • Feeling more tired than normal • Unable to do usual activity 	<p>Do you know why early recognition and treatment of stroke is important?</p>	<p>What are you going to watch for when you get home?</p> <ul style="list-style-type: none"> • B/P • Swelling of legs, hands, face, or stomach • Maintaining stable weight – no weight gain of more than 3 lbs. in one day • Activity ability • Urination 	<p>What symptoms should you report to your doctor or therapist?</p> <ul style="list-style-type: none"> • Unable to take medications • Not sleeping or sleeping too much • No appetite • Trouble paying attention • Hearing voices or voices getting worse • Have trouble taking care of your basic needs • Have tremors, rigid muscles, spasms, restlessness • Withdrawing from

Generic	Heart Failure	COPD	Stroke	Chronic Kidney Disease	Mental Health
					others
Patient should explain what to do if danger/red flags/signs or symptoms occur. <ul style="list-style-type: none"> What is the call to action (what to watch for)? What would you do if they occur? When would you call...? What would you do if...? Name three warning signs indicating the need to call your doctor? 911? 	<ul style="list-style-type: none"> What weight gain would you report to your doctor? Who would you call if you gain more than 3 lbs. in one day? 	What would you do if you were using your inhaler more than normal?	<ul style="list-style-type: none"> What signs or symptoms should you watch for to indicate you may be having a stroke? <ul style="list-style-type: none"> Five symptoms related to FAST Confusion, trouble speaking or seeing, dizziness Weakness or numbness B/P above targets Explain why you should call 911 instead of driving to the hospital if you are having a stroke. 	What symptoms would tell you to call your physician? <ul style="list-style-type: none"> B/P – top number over 180, bottom number over 100 More shortness of breath than usual Weight gain of 5 lbs. or more in 3 days Swelling in legs, ankles, stomach, hands, or face Not able to eat Metal taste in mouth Breath that smells like ammonia Fever about 101 degrees Fahrenheit Skin is itchy or you get a rash Trouble urinating or new blood in urine Unable to take your medications 	<ul style="list-style-type: none"> What is your plan of action for worrisome symptoms or situations? What should you watch for? What would you do if this happens? When would you call? Who would you call? What would you do if...?
Patient should explain key medications for principal diagnosis. <ul style="list-style-type: none"> Tell me what you know about... Can you tell me your medication schedule? 	What is the name of your water pill?	<ul style="list-style-type: none"> Do you know the name of your rescue inhaler? Show me how to use your inhaler. 	Can you describe the medication(s) you are taking to help prevent a stroke?	What is your schedule for taking your medications?	What situations should you avoid?
Patient should explain key points of eating plan.	What foods should you avoid?			What foods should you avoid?	
Patient should explain follow-up appointments. <ul style="list-style-type: none"> Importance of filling prescription Importance of scheduled follow-up appointments 	When will you see your physician next?	When will you see your physician next?	When will you see your physician next?	When is your next follow-up appointment and with whom?	Why is it important to keep your follow-up appointments?



Teach Back Competency Validation

Nursing Competency Assessment

- Annual competency validation day
- Methodology
 - The learning station will use discussion, role playing, and patient teaching scenarios to help RN's communicate effectively to patient/family.
- Each participant will participate in a role-play providing education to a patient. The following will be assessed:
 - Ability to do Teach Back in a shame-free way (e.g., tone is positive)
 - Utilizes plain language for explanations
 - Does not ask patient, "Do you understand?"

Staff Competency Validation for Teach Back

- Uses statements such as:
 - "I want to make sure I explained everything clearly to you. Can you please explain it back to me in your own words?"

OR

 - "I want to make sure I did a good job explaining this to you because it can be very confusing. Can you tell me what changes we decided to make and how you will take your medicine now?"
- If needed, participant will clarify and reinforce the explanation to improve patient understanding

Practice Sessions

- The scenarios are outlined below; they are identified with "B" for bad example and "G" for good example.
- Divide into groups of 2 to 3 people. Have one person be the nurse (who will read the scenario from the card), one person be the patient/family member and, if possible, a third to be the observer.
- Provide the nurse with several different scenarios to role play with.
- After going through the process with a few of the scenarios, have a debriefing with the group.

Evaluation/Discussion Questions

- What was the patient's reaction?
- What was it like for you as the nurse doing Teach Back?
- Did it feel like extra work?
- How would you build Teach Back into the daily work?
- How could you use Teach Back to communicate to the team?

Teach Back Practice #1-B

Read the following exactly as written as if you are teaching a patient.

I am going to talk to you about the signs of heart failure. The signs of heart failure are:

- Dyspnea on exertion
- Weight gain from fluid retention
- Edema in your lower extremities and abdomen
- Fatigue
- Dry, hacky cough
- Difficulty breathing when supine

Do you understand the signs you will be looking for?

Teach Back Practice #1-G

Read the following as written as if you are teaching a patient.

I am going to talk to you about the signs of heart failure. The signs of heart failure are:

- Shortness of breath
- Weight gain from fluid build-up
- Swelling in feet, ankles, legs, or stomach
- Dry hacky cough
- Feeling more tired, no energy

I know we just talked about a lot of things. Your wife wasn't able to be with us today. When she asks you what we talked about, what are you going to tell her?

Teach Back Practice #2-B

Read the following as if you are quizzing the patient. You are making the patient feel like they are on the spot by asking them to repeat the information you just told them. It sounds like a test for the patient.

I'm going to talk to you about what you need to do every day at home to control your heart failure.

Every day:

- Weigh yourself in the morning before breakfast and write it down
- Take your medication the way you should
- Check for swelling in your feet, ankles, legs, and stomach
- Eat low-salt food
- Balance activity and rest periods.

List four things for me that you are going to do every day?

Teach Back Practice #2-G

Read the following as written as if you are teaching a patient.

I'm going to talk to you about what you need to do every day at home to control your heart failure.

Every day:

- Weigh yourself in the morning before breakfast and write it down
- Take your medication the way you should
- Check for swelling in your feet, ankles, legs, and stomach
- Eat low-salt food
- Balance activity and rest periods

I teach people about this every day, and sometimes I go over it quickly or may not make myself clear. I want to make sure you know what you need to do. So, can you tell me some things you will do each day?

Teach Back Practice #2-G

Read the following as written as if you are teaching a patient.

I'm going to talk to you about what you need to do every day at home to control your heart failure.

Every day:

- Weigh yourself in the morning before breakfast and write it down
- Take your medication the way you should
- Check for swelling in your feet, ankles, legs, and stomach
- Eat low-salt food
- Balance activity and rest periods

We just discussed a lot of things for you to do every day. You might be doing some of these already. Have you already been doing any of these things? What do you think will be the hardest one for you to do at home?



Observation Guide: Observing Current Discharge Processes

Observe three patients on the day of discharge (i.e., last day of the hospital stay). Spend one to three hours with each patient and family members to discover what went well, what didn't work as planned or predicted and opportunities for improvement.

What do you predict you will observe?

Did the care team member(s)...	Patient # 1		Patient # 2		Patient # 3	
	Yes	No	Yes	No	Yes	No
Assess the patient's clinical status and determine readiness for discharge?	<input type="checkbox"/>					
Reconcile medications prior to completing instructions for the medication regimen prior to discharge?	<input type="checkbox"/>					
Initiate plans to ensure that the patient has the essential supplies and equipment for identified post-acute care needs?	<input type="checkbox"/>					
Provide a patient-friendly summary of home health care instructions tailored to the patient's and/or family caregiver's level of health literacy?	<input type="checkbox"/>					
Use Teach Back to assess the patient's understanding of the critical elements for self-care and medications?	<input type="checkbox"/>					
Arrange for the patient's transportation home or to a community setting?	<input type="checkbox"/>					
Arrange follow-up appointments in collaboration with the patient and/or family caregivers?	<input type="checkbox"/>					
Encounter any last minute problems causing delays in discharging the patient?	<input type="checkbox"/>					

Observation Guide: Observing Current Discharge Processes

Reflections after observations are completed (to be shared with the entire team):

What did you learn?

How did your observations compare to the predictions?

What, if anything, surprised you?

What new questions do you have? What are you curious about?

What assumptions about patient education that you held previously are now challenged?

As a result of the findings from these observations, what do you plan to test?

- 1.

- 2.

- 3.

- 4.

- 5.

How to Create A Pill Card (AHRQ)

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

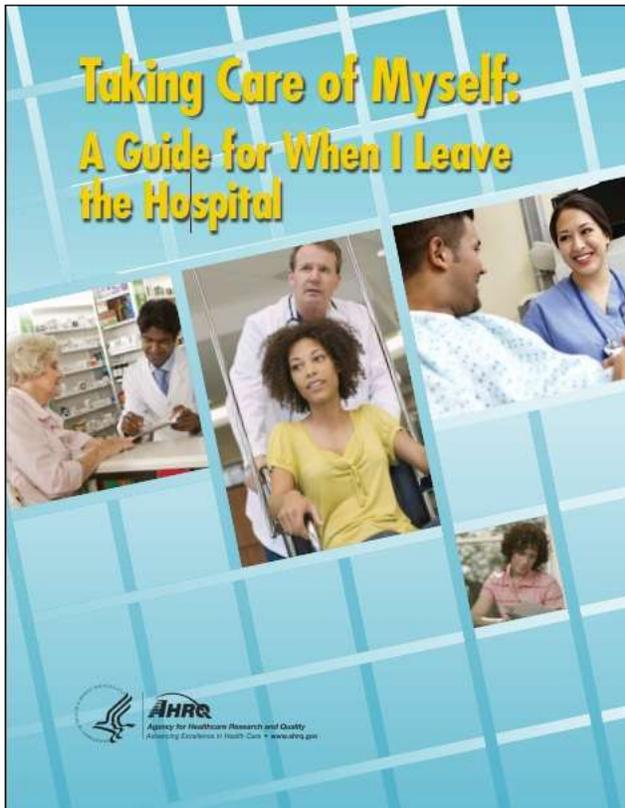
User-Friendly Medication Card (IHC)

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.)
- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Allergy medicine, antihistamines | <input type="checkbox"/> Cold/cough medicines | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Pain, headache or fever medicine |
| <input type="checkbox"/> Antacids (for heartburn or stomach) | <input type="checkbox"/> Diet pills | <input type="checkbox"/> Sleeping pills | <input type="checkbox"/> Other (List): _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Herbs, dietary supplements, hormones | <input type="checkbox"/> Vitamins, minerals | _____ |



To use this guide you should:

- Talk with the hospital staff about each of the items that are listed in the guide.
- Take the completed guide home with you. It will help you to take care of yourself when you go home.
- Share the guide with your family members and others who want to help you. The guide will help them know how to help take care of you.
- Bring the guide to all of your doctor appointments so the doctor knows what you have been doing to care for yourself since you left the hospital.

This guide is adapted from *Project Re-Engineered Discharge (RED)*, which was funded by AHRQ and conducted by Brian Jack, M.D., and colleagues at Boston University Medical Center. Additional tools for implementing Project RED are currently being developed.

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

When you leave the hospital, there are a lot of things you need to do to take care of yourself. You need to see your doctor, take your medicines, exercise, eat healthy foods, and know whom to call with questions or problems. This guide helps you keep track of all the things you need to do.

My name: _____

When I'm leaving the hospital _____

If I have questions or problems, I should call:

Phone number: _____

If I have a serious health problem, I should call:

Phone number: _____

Bring this plan to all your medical appointments.

1

What is my medical problem?

What are my medication allergies?

Where is my pharmacy?

What exercises are good for me?

What should I eat?

What activities or foods should I avoid?

2



What medicines do I need to take?

Each day, follow this schedule:

Morning Medicines

Medicine name (generic and name brand) and amount	Why am I taking this medicine?	How much do I take?	How do I take this medicine?

3



What medicines do I need to take?

Each day, follow this schedule:

Afternoon Medicines

Medicine name (generic and name brand) and amount	Why am I taking this medicine?	How much do I take?	How do I take this medicine?

4



What medicines do I need to take?

Each day, follow this schedule:

Evening Medicines

Medicine name (generic and name brand) and amount	Why am I taking this medicine?	How much do I take?	How do I take this medicine?

5



What medicines do I need to take?

Each day, follow this schedule:

Bedtime Medicines

Medicine name (generic and name brand) and amount	Why am I taking this medicine?	How much do I take?	How do I take this medicine?

6



What other medicines can I take?

	Medicine name and amount	How much do I take?	How do I take this medicine?
If I need medicine for a headache			
If I need medicine to stop smoking			
If I need medicine for			
If I need medicine for			
If I need medicine for			
If I need medicine for			
If I need medicine for			
If I need medicine for			
If I need medicine for			

7

When are my next appointments?

Day	Date
Time asdfasdf	
Doctor's name	Specialty
Address	
Reason for appointment	
Doctor's phone number	

Questions for my appointment

Check any of the boxes below and write notes to remember what to discuss with your doctor.

I have questions about:

- My medicines _____
 - My test results _____
 - My pain _____
 - Feeling stressed _____
- Other questions or concerns _____

8

When are my next appointments?

Day	Date
Time	
Doctor's name	Specialty
Address	
Reason for appointment	
Doctor's phone number	

Questions for my appointment

Check any of the boxes below and write notes to remember what to discuss with your doctor.

I have questions about:

- My medicines _____
 - My test results _____
 - My pain _____
 - Feeling stressed _____
- Other questions or concerns _____

9

When are my next appointments?

Day	Date
Time	
Doctor's name	Specialty
Address	
Reason for appointment	
Doctor's phone number	

Questions for my appointment

Check any of the boxes below and write notes to remember what to discuss with your doctor.

I have questions about:

- My medicines _____
 - My test results _____
 - My pain _____
 - Feeling stressed _____
- Other questions or concerns _____

10



Patient PASS: A Transition Record
 Patient Preparation to Address Situations (after discharge) Successfully

I was in the hospital because _____		
If I have the following problems ... 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	I should ... 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	Important contact information: 1. My primary doctor: _____ () _____ 2. My hospital doctor: _____ () _____ 3. My visiting nurse: _____ () _____ 4. My pharmacy: _____ _____ () _____ 5. Other: _____
My appointments: 1. _____ On: __/__/__ at __:__ am/pm For: _____ 2. _____ On: __/__/__ at __:__ am/pm For: _____ 3. _____ On: __/__/__ at __:__ am/pm For: _____ 4. _____ On: __/__/__ at __:__ am/pm For: _____	Tests and issues I need to talk with my doctor(s) about at my clinic visit: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	I understand my treatment plan. I feel able and willing to participate actively in my care: _____ Patient/Caregiver Signature _____ Provider Signature ____/____/____ Date
Other instructions: 1. _____ 2. _____ 3. _____		

Puget Sound Heart Failure Care Transition Summary Form <small>(FOR EFFICIENT HANDOFF FROM HOSPITALIZATION)</small>		 <small>WASCALACREDITED TO ACCREDITED BY THE NATIONAL COMMISSION ON ACCREDITATION FOR HEALTH CARE</small> <small>Tac. Gateway, RD. smp@low.edu</small>	
PATIENT NAME: John Doe	DATE OF BIRTH: 04/20/33	MEDICAL RECORD NUMBER: 222222	
CARE FACILITY: Harborview	FACILITY TYPE: Hospital		
ADMITTED (MM/DD/YY): 07/02/09	DISCHARGED (MM/DD/YY): 07/07/09	THIS FORM COMPLETED (MM/DD/YY): 07/07/09	
Heart Failure Diagnosis: Check Each Category: may be provisional or established diagnosis			
<input type="checkbox"/> Acute on Chronic		<input type="checkbox"/> AND <input type="checkbox"/> Systolic (EF < 40%) Heart Failure	
Heart Failure Care Essentials: assigned on admission or upon discovery of Heart Failure			
ACE/ARB ORDERED: <input checked="" type="checkbox"/> YES		CONTRAINDICATION: <input type="checkbox"/> NONE	
SMOKING CESSATION ADVICE DOCUMENTED (OR N/A): <input type="checkbox"/> YES			
LVEF DOCUMENTED: <input checked="" type="checkbox"/> YES	LVEF: 28.0 %	QUALITATIVE: <input type="checkbox"/> Quantitative listed	
CHECK EACH OF THE REQUIRED ELEMENTS OF TEACHING COMPLETED AND DOCUMENTED IN THE CHART:			
<input checked="" type="checkbox"/> WHAT TO DO FOR WORSENING SYMPTOMS	<input checked="" type="checkbox"/> DAILY WEIGHT AND GOAL WEIGHT	<input checked="" type="checkbox"/> MEDICATIONS AND THEIR PURPOSES	
<input checked="" type="checkbox"/> LIMITED SODIUM DIET	<input checked="" type="checkbox"/> ACTIVITY LEVEL AND LIMITATIONS	<input checked="" type="checkbox"/> FOLLOW-UP APPOINTMENT	
WHO WAS PRIMARY PERSON TAUGHT IN ADDITION TO PATIENT? Spouse		NAME: Jane Doe	
Heart Failure Treatments		Important Lab Values	
MEDICATION	Yes	Dose	LAB
ACE INHIBITOR	<input checked="" type="checkbox"/>	Lisinopril 10 mg BID	HEMATOCRT
ARB	<input type="checkbox"/>	NONE	INR/GOAL
DIURETIC	<input checked="" type="checkbox"/>	Furosemide 40 mg BID	SCOLIM
BETA BLOCKER	<input checked="" type="checkbox"/>	Carvedilol 12.5 mg BID	POTASSIUM
ALDOSTERONE ANTAGONIST	<input checked="" type="checkbox"/>	Eplerenone 25 mg daily	CREATININE
DIGOXIN	<input checked="" type="checkbox"/>	Digoxin 0.125 mg Every Day	BUN
ANTICOAGULANT THERAPY	<input checked="" type="checkbox"/>	Warfarin adjusted dose	BNP
ATTACH FULL LIST: <input checked="" type="checkbox"/> Attached	MEDICATION RECONCILIATION DONE: <input checked="" type="checkbox"/> YES	Other/Pending	Cx pending
DEVICE THERAPY: ICD and VVI Pacer		END OF LIFE DECISIONS: Other	
Body Weight			
ADMISSION WEIGHT: 78 Kg	DISCHARGE WEIGHT: 74 Kg	GOAL WEIGHT: 74 Kg	
Special Highlights of Hospital Course:			
Had transient fever attributed to atelectasis, cultures negative			
Health and Social Support			
PATIENT DISCHARGED TO: Home		WHO PROVIDES THE CARE AT HOME: Spouse	
CONTACT NAME: Jane Doe ; (206) 333-1111 PHONE		CONTACT INFO: NAME Jane Doe PHONE: (206) 333-1111	
Assessed Concerns and Limitations to Care			
<input type="checkbox"/> Cannot afford medications	<input type="checkbox"/> Deficit in Learning	<input type="checkbox"/> Deficit in ability to adhere to self care	<input type="checkbox"/> None
Clinical and Social Risks for Readmission:			
<input checked="" type="checkbox"/> HIGH: 2. Patient Failed Teach back		<input type="checkbox"/> INTERMEDIATE: Patient hospitalized once in the last year	
<input type="checkbox"/> LOW			
Hospital Handoff Transition Plan			
POST DISCHARGE CALL COMPLETED AT 48 HOURS <input checked="" type="checkbox"/>	HEART FAILURE FOLLOW-UP MD/ARNP/RN:	PCP FOLLOW-UP MD/ARNP/RN:	
APPOINTMENT FOR HIGH RISK PT AT 48-72 HRS <input checked="" type="checkbox"/>	NAME: Kathy Lee RN	NAME: Jane Smith MD	
PATIENT SCHEDULED WITH 7D POST DISCHARGE <input type="checkbox"/>	PHONE: 206 444 2223	PHONE: 206 555 4444	
	FAX: 206 444 2223	FAX: 206 555 4444	
Greatest Concerns			
PATIENT/CAREGIVER: Patient needs to understand adherence to care plan			
PROVIDER: medications must be tailored to affordability			
Whom to Call for Questions?		NAME: Kathy Lee RN ROLE: CHF Clinic RN	
PHONE: (206) 444-2222		FAX: (206) 444-2223	
THIS FORM GIVEN/SENT TO: Jane Doe and Dr Smith		THIS FORM COMPLETED BY: Kathy Lee RN	

DEMOGRAPHICS ON PATIENT		Activities of Daily Living	
PATIENT INFORMATION		Activity	
TRANSFERRED TO FACILITY/AGENCY _____		Independent	Supervision
PATIENT'S NAME _____ TELEPHONE _____		Assist/ # Persons	Unable to Do
LAST: _____ FIRST: _____		Turns Self	
ADDRESS _____		Sits	
CITY _____	STATE _____	Bed to Wheelchair	
	ZIP CODE _____	Transfers	
AGE _____	BIRTHDATE _____	Ambulation	
SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W	Bathing	
SOCIAL SECURITY # _____	MEDICARE # _____	Feeding	
	MEDICAID # _____	Dressing	
OTHER INSURANCE _____	INS # _____	Dental Care	
	AUTH # _____	Bedpan	
IN PATIENT _____	FROM _____	Bathroom	
	TO _____	Bedside Commode	
HOSPITAL ADMISSION DATES _____		HEIGHT _____	WEIGHT _____
PREVIOUS LIVING ARRANGEMENTS		DATE _____	
<input type="checkbox"/> Lives Alone	<input type="checkbox"/> Hospice	CONTINENT BLADDER <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Family	<input type="checkbox"/> Home/ Home Care	<input type="checkbox"/> CATHETER	SIZE _____ TYPE _____
<input type="checkbox"/> Home with Care Giver	<input type="checkbox"/> Passport	<input type="checkbox"/> SUPRAPUBIC	SIZE _____ TYPE _____
AGENCY _____	# _____	DATE INSERTED/ CHANGED _____	
PRIMARY CONTACT _____		CONTINENT BOWEL <input type="checkbox"/> YES <input type="checkbox"/> NO LAST BM _____	
<input type="checkbox"/> DPOA/HC		OSTOMY - TYPE _____ DATE CHANGED _____	
<input type="checkbox"/> DPOA		APPLIANCE _____	
<input type="checkbox"/> Legal Guardian		APPETITE/ NUTRITIONAL	
RELATIONSHIP TO PATIENT _____		DISABILITIES	
ADDRESS _____		<input type="checkbox"/> GOOD	<input type="checkbox"/> AMPUTATION
CITY _____	STATE _____	<input type="checkbox"/> FAIR	<input type="checkbox"/> PROSTHESIS
	ZIP CODE _____	<input type="checkbox"/> POOR	<input type="checkbox"/> PARALYSIS
HOME PHONE _____	WORK _____	<input type="checkbox"/> HYPERALIMENTATION	<input type="checkbox"/> PARESIS
	CELL PHONE _____	<input type="checkbox"/> FEEDING TUBE	<input type="checkbox"/> CONTRACTIONS
SECONDARY CONTACT/NEXT OF KIN		MENTAL STATUS	
NAME _____	PHONE _____	<input type="checkbox"/> ALERT	<input type="checkbox"/> COOPERATIVE
WHO WAS NOTIFIED OF TRANSFER ? _____		<input type="checkbox"/> ORIENTED	<input type="checkbox"/> BELLIGERENT
TREATMENT RECEIVED WITHIN LAST 14 DAYS		<input type="checkbox"/> DISORIENTED	<input type="checkbox"/> COMBATIVE
Chemotherapy <input type="checkbox"/> YES	DATE LAST RECEIVED _____	<input type="checkbox"/> FORGETFUL	<input type="checkbox"/> NOISY
Dialysis <input type="checkbox"/> YES		<input type="checkbox"/> UNRESPONSIVE	<input type="checkbox"/> ABUSIVE
IV Medications <input type="checkbox"/> YES		<input type="checkbox"/> DEPRESSED	<input type="checkbox"/> PASSIVE
Oxygen therapy <input type="checkbox"/> YES		SENSORY IMPAIRMENTS	
Transfusions <input type="checkbox"/> YES		VISION <input type="checkbox"/> ADEQUATE <input type="checkbox"/> POOR <input type="checkbox"/> BLIND	
Radiation <input type="checkbox"/> YES		HEARING <input type="checkbox"/> ADEQUATE <input type="checkbox"/> POOR <input type="checkbox"/> DEAF	
Ventilator <input type="checkbox"/> YES		HEARING AID <input type="checkbox"/> L <input type="checkbox"/> R	
Tracheotomy Care <input type="checkbox"/> YES		SPEECH <input type="checkbox"/> CLEAR <input type="checkbox"/> DIFFICULT <input type="checkbox"/> APHASIA	
Suctioning <input type="checkbox"/> YES		<input type="checkbox"/> SPEAKS ENGLISH	
Pneumonia Vaccine <input type="checkbox"/> YES		<input type="checkbox"/> INTERPRETER REQUIRED	
Flu Vaccine <input type="checkbox"/> YES		SKIN CARE	
Mantoux <input type="checkbox"/> YES		SKIN INTACT? <input type="checkbox"/> Y <input type="checkbox"/> N	
Vital Signs Range: _____		DESCRIBE DECUBITUS/ WOUND - SIZE (CMs), SITE, DRAINAGE	
Last Blood Sugar _____	Result: _____		
Date: _____			
Last Pulse Ox (SaO2) _____	Result: _____		
Date: _____			
PAIN ASSESSMENT		DNR: TRANSFERRING FACILITY [ATTACH COPY]	
<input type="checkbox"/> None <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Intermittent <input type="checkbox"/> Sharp <input type="checkbox"/> Dull		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> CC <input type="checkbox"/> CCAREST <input type="checkbox"/> OTHER DRN
<input type="checkbox"/> Other (explain) _____		ADVANCE DIRECTIVES [ATTACH COPY]	
LOCATION: _____		LIVING WILL <input type="checkbox"/> YES <input type="checkbox"/> NO	
INTENSITY (1 - 10) _____		DURABLE POWER OF ATTORNEY/HC <input type="checkbox"/> YES <input type="checkbox"/> NO	
ISOLATION	SITE	SMOKING CESSATION ADDRESSED <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> CDIFF <input type="checkbox"/> ESBL			
Site: _____			
Other Instructions: _____			
PERSONAL POSSESSIONS SENT WITH PATIENT ON DAY OF TRANSFER		 AKRON REGIONAL HOSPITAL ASSOCIATION	
<input type="checkbox"/> Glasses <input type="checkbox"/> Purse/ Wallet			
<input type="checkbox"/> Dentures/ Partials <input type="checkbox"/> Medications			
<input type="checkbox"/> Hearing Aid <input type="checkbox"/> Walker/ Cane			
<input type="checkbox"/> Other _____			
Signature of Person Completing Form: _____	Date: _____		
SW/ Case Manager Signature: _____	Date: _____		
Unit Phone Number: _____			



AKRON REGIONAL HOSPITAL ASSOCIATION

POST ACUTE TRANSFER FORM

COPY AND SEND TO THE NURSING FACILITY IN THE ORDER LISTED

Chart Form	Content Needed for Admission	Check Off
Post Acute Skilled Transfer Form	Make sure the secondary payer source area is completed	
MARs	Include the most recent MAR and MARs that have the last dose of an IV med, injections or any chemo (IV or PO). Documentation of blood transfusions	
PT, OT, Speech & Respiratory Therapy	Include the evaluation and notes for last week of stay	
Nutrition Evaluation Form		
Medications	If not individually listed on form, attach computerized listing	
DNR Order Sheet	Either the state form or the hospital form if applicable	
Advanced Directives	Copies of Living Will and/or Durable Power of Attorney for Health Care if on chart	
Physician's Progress Notes	Notes from last 3-4 days	
Nurse's notes/Social Work Notes	Notes from last 2 days; include discharge planning notes; notes including detail on PICC line insertion	
Consultations	A copy of each consult	
Laboratory Results	Most recent labs, including U/A, C&S, CBC, electrolytes, labs used to track dosing of meds (ex; Theophylline/Dilantin level, INRs), MANTOUX	
CXR, EKG	Include most recent	
Cookie Swallow, MRIs, CT Scans	If done, most recent	
H&P and Nursing Assessment with home med sheet	If H&P is dated prior to 5 days before discharge, physician must review, sign, and date	
PASARR ID	Completed Form & results	

Partnering with Patients and Families to Accelerate Improvement Readiness Assessment

Name of Organization _____

			
Area	Current Experience: Make a mark (an X, a circle, or anything that is easy to read) in the box that best describes your team or organization's experience.		
Data transparency	We have not discussed the possibility of sharing performance data with patients and family members.	Our team is comfortable with sharing improvement data with patients and families related to current improvement project.	This organization has experience with sharing performance data with patients and families.
Flexibility around the aims and specific changes of the improvement project	We have limited ability to refine the project's aims or planned changes.	We have some flexibility to refine the project's aims and the planned changes.	We are open to changing both the aims and specific changes that we test based on patient and family team members' perspective.
Underlying fears and concerns	We have not discussed our concerns about involving patient and families on improvement teams.	We have identified several concerns related to involving patients and families on improvement teams but have no plan for how to address or manage them.	We have a plan to manage and/or mitigate issues that may arise due to patient and family member involvement on our team.
Perceived value and purpose of patient/family involvement	There is no clear agreement that patient and family involvement on improvement teams is necessary to achieve our current improvement aim.	A few of us believe patient and family involvement would be beneficial to our improvement work, but there is not universal consensus.	There is clear recognition that patient and family involvement is critical to achieving our current improvement aim.

Senior leadership support for patient and family involvement	Senior leadership do not consider patient and family involvement a top priority.	Senior leaders are aware of and communicate support for patient and family involvement in our team.	Senior leaders consider our participation in this program as a pilot for organizational spread.
Experience with patient and family involvement	Beyond patient satisfaction surveys or focus groups our organization does not have a formal method for patient/family feedback.	We have an active patient/family advisory panel.	Patient and families are members of standing committees and make decisions at the program and policy level.
Collaboration and teamwork	Staff in this organization occasionally work in multidisciplinary teams to provide care.	Staff in this organization work effectively across disciplines to provide care to patients.	Patients and family are included as valued members of the care team in this organization.
<ol style="list-style-type: none"> 1. What supports moving in this direction? 2. What are your current challenges? 3. How confident are you on successfully involving patients and families on your team (1-10 scale)? 			

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Diagnostic Worksheet: In-depth Review of Patients Who Were Readmitted

Part 1: Chart Reviews of Patients

Conduct chart reviews of the last five readmitted patients. Reviewers should be physicians or nurses experienced in the clinical setting and in chart review for quality and safety. Reviewers should not look to assign blame, but rather to discover opportunities to improve the care of patients. Worksheet Part 3 is a reference list of typical failures. The intent is to learn how we might prevent these failures that we once thought impossible to prevent.

Question	Patient #1		Patient #2		Patient #3		Patient #4		Patient #5	
Number of days between the last discharge and this readmission date?	_____ days									
Was the follow-up physician visit scheduled prior to discharge?	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
If yes, was the patient able to attend the office visit?	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
Were there any urgent clinic/ED visits before readmission?	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
Functional status of the patient on discharge?	Comments:									
Was a clear discharge plan documented?	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
Was evidence of "Teach Back" documented	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
List any documented reason/s for readmission	Comments:									
Did any social conditions (transportation, lack of money for medication, lack of housing) contribute to the readmission?	Yes <input type="checkbox"/>	No <input type="checkbox"/>								

Diagnostic Worksheet: In-depth Review of Patients Who Were Readmitted
Part 1: Reflective Summary of Chart Review Findings

What did you learn?

What themes emerged?

What, if anything, surprised you?

What new questions do you have?

What are you curious about?

What do you think you should do next?

What assumptions about readmissions that you held previously are now challenged?

Diagnostic Worksheet: In-depth Review of Patients Who Were Readmitted

Part 2: Interviews with Patients, Family Members, and Care Team Members in the Community

If possible, conduct the interviews on the same patients from the chart review. Use a separate worksheet for each interview.

Ask Patients and Family Members:

How do you think you became sick enough to come back to the hospital?

Did you see your doctor or the doctor's nurse in the office before you came back to the hospital?

Yes

If yes, which doctor (PCP or specialist) did you see?

No

If no, why not?

Describe any difficulties you had to get an appointment or getting to that office visit.

Has anything gotten in the way of your taking your medicines?

How do you take your medicines and set up your pills each day?

Describe your typical meals since you got home.

Ask Care Team Members in the Community:

What do you think caused this patient to be readmitted?

After talking to the care team members about why they think the patient was readmitted, write a brief story about the patient's circumstances that contributed to the readmission.

Diagnostic Worksheet: In-depth Review of Patients Who Were Readmitted
Part 2: Summary of Interview Findings

What did you learn?

What themes emerged?

What, if anything, surprised you?

What new questions do you have?

What are you curious about?

What do you think you should do next?

What assumptions about readmissions that you held previously are now challenged?

Diagnostic Worksheet: In-depth Review of Patients Who Were Readmitted

Part 3: List of Typical Failures in Discharge Preparations

Typical failures associated with patient assessment:

- Failure to actively include the patient and family caregivers in identifying needs, resources, and planning for the discharge;
- Unrealistic optimism of patient and family to manage at home;
- Failure to recognize worsening clinical status in the hospital;
- Lack of understanding of the patient's physical and cognitive functional health status may result in a transfer to a care venue that does not meet the patient's needs;
- Not addressing whole patient (underlying depression, etc.);
- No advance directive or planning beyond DNR status;
- Medication errors and adverse drug events; and
- Multiple drugs exceed patient's ability to manage.

Typical failures found in patient and family caregiver education:

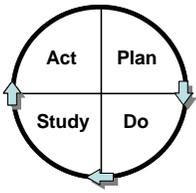
- Assuming the patient is the key learner;
- Written discharge instructions that are confusing, contradictory to other instructions, or not tailored to a patient's level of health literacy or current health status;
- Failure to ask clarifying questions on instructions and plan of care; and
- Non-adherent patients (resulting in unplanned readmissions): lack of compliance with self-care, diet, medications, therapies, daily weights, follow-up and testing; or lack of adherence due to patient and/or family-caregiver confusion.

Typical failures in handover communication:

- Poor hospital care (evidence-based care missing/incomplete);
- Medication discrepancies;
- Discharge plan not communicated in a timely fashion or adequately conveying important anticipated next steps;
- Poor communication of the care plan to the nursing home team, home health care team, primary care physician, or family caregiver;
- Current and baseline functional status of patient rarely described, making it difficult to assess progress and prognosis;
- Discharge instructions missing, inadequate, incomplete, or illegible;
- Patient returning home without essential equipment (e.g., scale, supplemental oxygen, or equipment used to suction respiratory secretions);
- Having the care provided by the facility unravel as the patient leaves the hospital (e.g., poorly understood cognition issues emerge); and
- Poor understanding that social support is lacking.

Typical failures following discharge from the hospital:

- Medication errors;
- Discharge instructions that are confusing, contradictory to other instructions, or are not tailored to a patient's level of health literacy;
- No follow-up appointment or follow-up needed with additional physician expertise;
- Follow-up too long after hospitalization;
- Follow-up is the responsibility of the patient;
- Inability to keep follow-up appointments because of illness or transportation issues;
- Lack of an emergency plan with number the patient should call first;
- Multiple care providers; patient believes someone is in charge;
- Lack of social support; and
- Patient lack of adherence to self-care (e.g., medications, therapies, daily weights, or wound care) because of poor understanding or confusion about needed care, transportation, how to get appointments, or how to access or pay for medications.



PDSA Worksheet

DATE _____

Change or idea evaluated: _____

Objective for this PDSA Cycle: _____

What question(s) do we want to answer on this PDSA cycle?

Plan:

Plan to answer questions (test the change or evaluate the idea): Who, What, When, Where

Plan for collection of data needed to answer questions: Who, What, When, Where

Predictions (for each question listed, what will happen if plan is carried out? Discuss theories)

Do:

Carry out the Plan; document problems and unexpected observations; collect data and begin analysis.

Study:

Complete analysis of data; What were the answers to the questions in the plan (compare to predictions)? Summarize what was learned.

Act:

What changes are to be made? Plan for the next cycle



Example Completed PDSA Worksheet

DATE: 8/10/2010

Change or idea evaluated: Use HF Zone handout to improve patient learning

Objective for this PDSA Cycle: Improve patient understanding of HF self-care by using the zone worksheet, improve nurse teaching skills

What question(s) do we want to answer on this PDSA cycle?

If we use health literacy principles and teach-back, will (1) our nurses be comfortable using the teach-back technique, and (2) our patients have a better understanding of their care?

Plan:

Plan to answer questions (test the change or evaluate the idea): Who, What, When, Where

Emily will talk to Jane (a nurse we know is interested in this project) and ask her to try the change

A HF patient with sufficient cognitive ability (Jane will decide) will be identified on August 10

Jane will use HF zone handout example from St. Luke's as teaching tool

Jane will ask four St. Luke's sample questions:

- What is the name of your water pill?
- What weight gain should you report to your doctor?
- What foods should you avoid?
- Do you know what symptoms to report to your doctor?

Plan for collection of data needed to answer questions: Who, What, When, Where

Jane will write down which answers patients were able to Teach Back successfully and which they had trouble with and come to the next team meeting on the 11th and report on her experience

Predictions (for each question listed, what will happen if plan is carried out? Discuss theories)

- 1) Nurse may have trouble remembering not to say "do you understand" But will like the change, be able to use the technique, and
- 2) The patient will be able to teach back (will choose someone with sufficient cognitive Ability for the test)

Do:

Carry out the Plan; document problems and unexpected observations; collect data and begin analysis.

There wasn't an appropriate patient on the 10th, but there was on the 11, Jane reported to the team the next day that the patient was able to teach back three of the four questions – had trouble remembering weight gain to report to doctor. Jane reported that she really liked the new teaching style and wanted to practice it with other patients.

Study:

Complete analysis of data; What were the answers to the questions in the plan (compare to predictions)? Summarize what was learned.

Jane reported that she did say “do you understand” a couple of times and then would catch herself, but she had explained the test in advance to the patient and they liked the idea, too.

Act:

What changes are to be made? Plan for the next cycle

Find one or more patients willing to work with Jane on redesigning patient materials and continue to test the Teach Back technique – Jane will try on more patients and try to recruit another nurse to test with her. Will report back at next meeting. Jane will create a paper tool that will help her keep track of which items the patients teach back so that she can continue to collect the data.

Spread Tracker Template

A=Planning B=Start C=In Progress D=Fully Implemented

	Pilot Unit 1	Pilot Unit 2	Spread Unit 1	Spread Unit 2	Spread Unit 3
Change 1	D	C	A	B	C
Change 2	D	C	B	B	C
Change 3	D	C	A	A	C
Change 4	D	C	B	A	B
Change 5	C	D	C	C	A
Change 6	C	D	C	C	A
Change 7	C	D	A	C	A
Change 8	C	D	A	C	A

Signs of Heart Failure

If you have one or more of these symptoms:

- Weight gain of 3 pounds in 1 day or
- Weight gain of 5 pounds or more in 1 week
- More shortness of breath
- More swelling of your feet, ankles, legs or stomach
- Feeling more tired – no energy
- Dry, hacking cough
- Harder to breathe when lying down
- Chest pain

Call doctor _____

at _____



**ST. LUKE'S
HOSPITAL**
IOWA HEALTH SYSTEM

VISITING
NURSE
ASSOCIATION

<p>EVERY DAY</p>	<p>Every day:</p> <ul style="list-style-type: none"> • Weigh yourself in the morning before breakfast and write it down. • Take your medicine the way you should. • Check for swelling in your feet, ankles, legs and stomach • Eat low salt food • Balance activity and rest periods <p>Which Heart Failure Zone are you today? Green, Yellow or Red</p>
<p>GREEN ZONE</p>	<p>All Clear <u>This zone is your goal</u> Your symptoms are under control You have:</p> <ul style="list-style-type: none"> • No shortness of breath • No weight gain more than 2 pounds (it may change 1 or 2 pounds some days) • No swelling of your feet, ankles, legs or stomach • No chest pain
<p>YELLOW ZONE</p>	<p>Caution <u>This zone is a warning</u> Call your doctor's office if:</p> <ul style="list-style-type: none"> • You have a weight gain of 3 pounds in 1 day <u>or</u> a weight gain of 5 pounds or more in 1 week • More shortness of breath • More swelling of your feet, ankles, legs, or stomach • Feeling more tired. No energy • Dry hacky cough • Dizziness • Feeling uneasy, you know something is not right • It is harder for you to breathe when lying down. You are needing to sleep sitting up in a chair
<p>RED ZONE</p>	<p>EMERGENCY Go to the emergency room or call 911 if you have any of the following:</p> <ul style="list-style-type: none"> • Struggling to breathe. Unrelieved shortness of breath while sitting still • Have chest pain • Have confusion or can't think clearly



A better place to be

Low Sodium Eating Plan

2000mg Sodium



Low Sodium Eating Plan

2,000mg Sodium

Salt is also called "sodium" and is found in most foods you eat.

Why do you need to limit sodium in your diet?

Sodium acts like a sponge and makes your body hold onto water. Eating too much sodium can cause you to gain weight, make your legs swell, and cause water to collect in your lungs.

How much sodium can you have each day?

Doctors recommend that you eat less than 2000mg of sodium each day. This means taking the salt shaker off of your table and paying attention to the types of foods you eat.

The First Steps...

1. Do not add salt to foods when you cook or at the table
2. Use herbs and seasonings like Mrs. Dash that are sodium free
3. Start with fresh foods
4. Do not use instant foods that come in a can, bag, or box

Eat Less Added Salt

Choose this:

Mrs. Dash	Onion Powder
Spices	Garlic Powder
Herbs	Oil and Vinegar
Lemon Juice	Pepper
Hot Sauce	
Fresh Garlic, Onion, Green Pepper	
Ketchup labeled "No Salt Added"	



Do not choose this:

Salt	Sea Salt
Seasoning Salts	Mustard
Meat tenderizer	Ketchup
Soy Sauce	BBQ Sauce
Garlic Salt	Onion Salt
Bottled Salad Dressing	Bouillon
Olives	Sauerkraut
Relishes	Pickles
Cheese Sauce	Onion Soup Mix



Eat Less Salty Snacks

Choose this:

Crackers labeled "Hint of Salt"
Unsalted nuts
Unsalted popcorn (air popped, also available in microwaveable)
Unsalted potato or tortilla chips
Fruit
Raw Vegetables



Do not choose this:

Salted crackers
Salted popcorn
Salted nuts
Pretzels
Salted chips
Jerky



Eat Less Canned Food

Choose this:

Homemade soup made with low sodium bouillon or homemade stock
Fresh or Frozen Vegetables
Tomato Juice labeled "Low Sodium"
Canned Vegetables labeled "No Salt Added"
Canned Tuna or Salmon labeled "Low Sodium" or "Very Low Sodium"
Canned Fruit



Do not choose this:

Canned soups
Canned fish (tuna, salmon, sardines)
Canned vegetables
Canned meat (chicken, beef, Spam)
Canned entrees (pastas, stews)
Baked Beans, Pork and Beans
Canned vegetable juice



Eat Less Cured Food

Choose this:

Fresh Meat
Peanut Butter
Eggs, Egg Substitute
Dried Beans



Do not choose this:

Ham	Hot dogs
Salt pork	Pastrami
Bacon	Corned Beef
Sausage	Bologna
Frozen Chicken Breasts	Smoked fish
Cold cuts (Luncheon Meat)	



Eat Less Processed Food

Choose this:

Swiss cheese
Milk
Yogurt
TV Dinners with less than 600mg sodium (Healthy Choice, Lean Cuisine, Smart Ones)
Quick cooking or Old Fashioned Oatmeal
Cream of Wheat
Puffed Corn, Puffed Rice
Shredded Wheat



Do not choose this:

Cheese
TV Dinners (More than 600mg sodium)
Box Meals (Hamburger Pasta Meals, Macaroni and Cheese)
Instant Rice Mixes
Instant Noodle Mixes
Cake Mixes
Pre-made cakes and pies
Fast Food



June 2010

**Heart Failure Workshop
June 26**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1 My Weight	2 My Weight	3 My Weight	4 My Weight	5 My Weight
6 My Weight	7 My Weight	8 My Weight	9 My Weight	10 My Weight	11 My Weight	12 My Weight
13 My Weight	14 My Weight	15 My Weight	16 My Weight	17 My Weight	18 My Weight	19 My Weight
20 My Weight	21 My Weight	22 My Weight	23 My Weight	24 My Weight	25 My Weight	26 My Weight
27 My Weight	28 My Weight	29 My Weight	30 My Weight	<p>Have you taken a walk yet today?</p> 		

Find the local farmer's market to get fresh vegetables. At picnics have fresh



hamburger instead of bratwurst or hot dogs.

Heart Failure Workshop
9:00 a.m. to 12:00 p.m.
FREE
Heart Center
Classrooms-3rd Floor



ST. LUKE'S HOSPITAL
IOWA HEALTH SERVICES
A better place to be

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