LeaderBriefing

Lost in Transition

Why Changing the Way We Think About Coordination and Communication Across the Care Continuum is Essential to Improve Outcomes

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Since 1983 when Medicare launched the prospective payment system (PPS), the average inpatient hospital stay has declined from 10.0 to 4.5 days. During this same period, Medicare discharges to skilled nursing increased four-fold.[i] Health care providers are well aware that patients are being discharged at a higher acuity and with far more significant needs for continuing care. What often is not recognized is how vulnerable patients are during transitions between care settings, especially older adults and those with multiple comorbidities.

Effective Care Transitions are Key to Better Outcomes and Patient Experience

Poor communication and coordination during care transitions can contribute to adverse events and preventable hospital readmissions. As health care providers and systems are incentivized to manage episodes of care beyond the inpatient stay, hospitals increasingly are under pressure to transform the traditional discharge planning paradigm to more robust care transition management and coordination.

This **LeaderBriefing** from Stamp&Chase explores how healthcare organizations must move beyond discrete, provider-centric tactics to patient-centered collaboration. By addressing disconnects across the care team and with patients, providers can ensure that they are having the right conversations at the right time – and in the right way – so that patients and their caregivers experience the best outcomes possible.

Patients Tell Us Better Discharge Instructions Is Not What They Want – or Need

A recent study published in the Annals of Family Medicine, "*Care Transitions from Patient and Caregiver Perspectives*," looks closely at what matters most to patients and caregivers during care transitions[ii]. The need for and purpose of the study were clear:

> *Despite concerted actions to streamline care transitions, the journey from hospital to home remains hazardous for patients and caregivers. Remarkably little is known about the patient and caregiver experience during care transitions, the services they need, or the outcomes they value. The aims of this study were to (1) describe patient and caregiver*

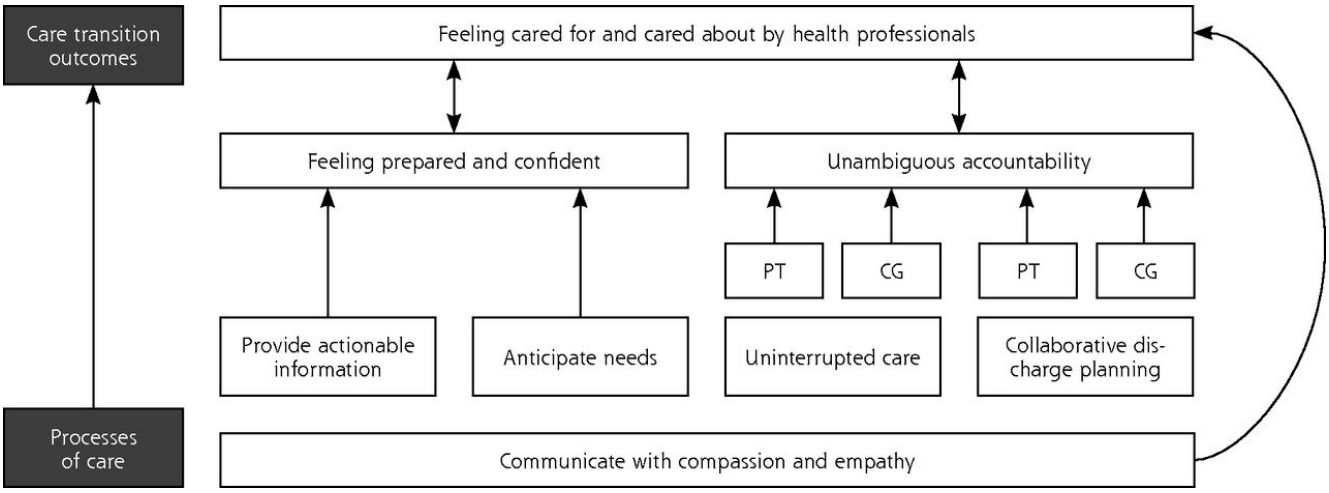
experiences during care transitions and (2) characterize patient and caregiver desired outcomes of care transitions and the health services associated with them.

Patients and caregivers identified three primary desired outcomes of care transitions:

- To feel cared for and cared about by medical providers,
- To have unambiguous accountability from the healthcare system, and
- To feel prepared and capable of implementing care plans.

And five key characteristics of the care transition experience were linked to achieving these outcomes:

- Using empathetic language and gestures,
- Anticipating the patient's needs to support self-care at home,
- Collaborative discharge planning,
- Providing actionable information, and
- Providing uninterrupted care with minimal handoffs.



From "*Care Transitions from Patient and Caregiver Perspectives*"

The authors concluded that: *"Clear accountability, care continuity, and caring attitudes across the care continuum are important outcomes for patients and caregivers. When these outcomes are achieved, care is perceived as excellent and trustworthy. Otherwise the care transition is experienced as transactional and unsafe, and leaves patients and caregivers feeling abandoned by the health care system."*

What is *not* called for in this study – or in Stamp&Chase's experience working with a variety of care providers – is the need for more detailed, standard discharge instructions without true collaboration with patients, family caregivers and/or post-acute care facilities.

What could possibly go wrong?

A single episode of care often involves multiple physicians, advanced practice providers, nurses and other clinical professionals in several care settings. That means there are many opportunities for miscommunication and gaps in coordination. For care transitions to occur effectively and seamlessly, there must be:

- Effective hand-off communication between care team members at every step,
- Reconciliation of any unresolved care issues, including medication changes or pending test results,
- Successful engagement of the patient and family caregivers in the development and implementation of the care and transition plans,
- Exchange of vital patient information across the provider continuum, including both the comprehensive care plan and specific areas of highest risk for readmission or decline in condition, and
- Follow-up with the patient and family caregivers to assess status and compliance with the care plan.

With this many moving parts, a variety of factors can contribute to problematic patient care transitions. But according to a report from the Joint Commission Enterprise *Transitions of Care Initiative*[iii], the root causes most often described in the medical literature come down to just three:

- Communication breakdowns
- Patient education breakdowns
- Accountability breakdowns

Strategies to Address the Most Common Problems in Care Transitions

Specific, intentional strategies to address breakdowns in communication, patient education and accountability are necessary to make sustainable improvements in care coordination across the continuum. The following three sections provide recommendations for making progress in these critical areas.

Communication Across the Care Team: Who's On First?

Miscommunication is epidemic in most hospitals. In focus group research conducted with front line hospital staff by Stamp&Chase, most caregivers could quickly site a communication error that occurred *in the past few days* that affected productivity, safety and/or the care experience. These communication failures can be caused by a variety or combination of factors:

- Organizational culture lacking in teamwork and mutual respect
- Differing or conflicting expectations
- Absence of active listening to ensure real understanding
- Lack of focus
- Frequent interruptions
- Inconsistent or deficient standardized procedures

How often have we seen busy clinicians think that they have communicated information clearly but in fact there is a lack of understanding and agreement with colleagues and/or patients. Sometimes team communication may even seem reminiscent of the famous Abbott and Costello comedy routine, "*Who's on First*" where Bud Abbott is naming the players he manages on the Retired Actors baseball team: "Who is on first, What is on second, I don't know is on third…" During the conversation they talk right past each other, as Lou Costello grows increasingly frustrated. Unlike a comedy routine, breakdowns in communication between healthcare providers and families are anything but funny and can have devastating consequences.

In **CAREmunication®**, Stamp&Chase's comprehensive professional development curriculum focused on improving communication competencies and practices, we use a structured model that is effective in conversations from the most routine to the most complex. Rather than relying on situation-specific scripting, which we believe is frustrating for both professionals and for patients, the C.A.R.E. model encourages and develops critical thinking skills to leverage communication practices that are most effective and appropriate given the circumstances.

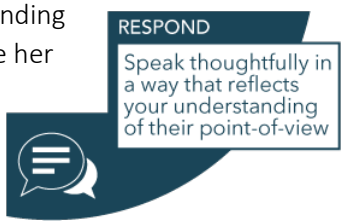
The C.A.R.E. Approach to Better Communication

Using a structured, thoughtful approach to the way we enter any conversation with a patient, family member, physician or colleague can help make our communication more effective. The components of the C.A.R.E. Model are designed to help us better focus our messages and communication, assure understanding, respond thoughtfully and evaluate how effectively we are interacting with others.

It is difficult, if not impossible, for communication to occur in a frenzied state of mind. Whether you are delivering a message or listening to one, **composing** your thoughts and focusing on the purpose of the exchange and on the other person are the essential first steps in achieving accurate, satisfying communication. Active listening is critical during all stages of communication.

Even if you disagree with the content or opinions expressed in a conversation, **acknowledge** that you've heard and understand what the other person is trying to communicate to you. Knowing where the other person is coming from means thinking about more than just facts and figures; acknowledging how they feel about the issue leads to better understanding. If you are unclear on any point, ask for clarification. And if you've initiated the conversation, don't assume that your audience has necessarily grasped everything you've said.

Having acknowledged the other person's message and point of view, now **respond** with your own thoughts in the same measured, reasoned way you listened. Responding in a way that recognizes your understanding of the other person's opinions and feelings can actually make her more open to hearing and considering your ideas. Use what you've learned during the "acknowledge" step to craft a response that best addresses the other person's key issues and concerns.



Effective communication requires a willingness to not just understand but to critically **evaluate** another's message vis-à-vis your own statements and opinions. How is the conversation going? Are you gaining the other person's understanding and buy-in? If the exchange is not going well, what aspects of your approach – compose, acknowledge and/or respond – do you need to adjust to achieve the best results?

Patient and Family Education: Did We Miss Something?

By definition, **patient education** is the process by which health care professionals and others impart information to patients and their family caregivers that will alter their health behaviors or improve their health status. This implies a two-way, collaborative process that requires an essential connection between communicator and receiver.

Sensory impairments (hearing loss, blindness) or language differences are obvious barriers to patient communication and engagement, but other factors can be more elusive – and sometimes more seriously impact outcomes.

- **Poor Health Literacy** – The Department of Health & Human Services reported that only 12% of Americans have a "proficient" level of health literacy, and more than one-third of U.S. adults have difficulty in completing common health tasks like following directions on prescription drug labels or other care instructions.[iv]
- **Cognitive Impairment** – The inability to read, understand written health information and to remember the required routine can contribute to nonadherence with discharge instructions, medications plans and failure to follow up with care providers.
- **Social Determinants of Health** – Medically underserved and low socioeconomic status patients, who comprise about 30% of patients discharged from hospitals, are at higher risk of adverse events following discharge and can pose particular challenges for care transition management.[v]

When patients and family caregivers receive conflicting or confusing information or are excluded from care transition planning, they often do not buy into the importance of following the care plan. Additionally, patients may lack the required knowledge, skills or means to comply with even the most seemingly basic instructions. Studies in the U.S. have shown that non-adherence to medications causes 125,000 deaths annually and accounts for 10 to 25 percent of hospital and nursing home admissions.[vi]

Stamp&Chase advocates two primary practices to improve patient education and compliance.

Ask and Encourage More Questions

While printed care plan and discharge instructions are necessary, they stop far short of providing the understanding every patient needs to recover successful and/or make the transition to the next level of care confidently. The problem with standard instructions is that they assume every patient has the same questions, concerns, fears and cognitive abilities. Of course, we know that's not the case.

The conversation we should have with each patient and their family caregivers *customizes* information and ensures real understanding. But that customization can only happen when we get the patient talking.

"Do you have any more questions?" is unfortunately our go-to question for assessing whether patients and their caregivers have what they need to successfully transition. The problem with that closed-ended, yes/no questions is that it often appears to be asked rhetorically and seldom makes patients comfortable actually asking for clarification and more details.

"What other questions do you have that I can help you with?" is an open-ended invitation for the patient to ask more. This question communicates that the care professional actually expects the patient to have questions.

But patients sometimes still don't open up and share their underlying concerns and confusion. How do we know when this is happening? Their non-verbal facial expressions, tone of voice and gestures usually communicate to us what they are not sharing in words. If it is clear that the patient still has questions, then reassurance is helpful. "All patients have questions about these care plans. What are the areas you'd like to discuss further?" or "What concerns you most about going home?" helps open the door when patients are reluctant to ask.

Modified Teach-Back

Teach-back is a well-known, tried-and-true approach advocated by The Joint Commission and other agencies to improve patient education. Essentially, teach-back suggests that the patient repeat back or demonstrate what you've just told them. The problem with teach-back is that with some patients it can feel either intimidating or degrading. While the basic philosophy is certainly sound, *how* you introduce and use teach-back can make a major difference in its success.

Stamp&Chase recommends a modified teach-back model that encourages care professionals to emphasize first their concern and interest in how well they've communicated rather than how well the patient can repeat back instructions. Consider these two different approaches for introducing teach-back:

- "Those are the instructions. Can you repeat back those steps to me?" vs.
- "I've given you lots of details. Why don't you go back over them with me so I can be sure I explained everything well?"

The difference may seem subtle, but how the request is perceived by the patient can be dramatically different. The first can appear intimidating, especially if the

patient really does not understand all of the instructions and may be embarrassed. The second communicates that not understanding every detail initially is more than all right; it is expected.

Who Should Be the Captain of the Care Transition Process?

In too many healthcare organizations, no single clinical department or individual has responsibility for assuring that a patient's care is coordinated across settings and among different providers. During acute hospitalization, a discharge planner or case manager is typically responsible for coordinating discharge arrangements, but these individuals usually do not focus on execution of the care plan across settings or the entire episode of care. Additionally, they often do not have responsibility for, arguably, one of the most important aspects of successful care transitions: patient education.

In an effort to encourage providers to serve in a true care coordination role, CMS introduced in 2013 the **Medicare Transition of Care Management (TCM)** program. By using new TCM CPT codes, physicians can receive a one-time payment for managing transitional care of selected patients during the 30-day period following a hospital discharge.[vii]

Up to two thirds of Medicare beneficiaries qualify for this program following an inpatient hospital stay; however, Medicare claims were submitted for only 7 percent of eligible cases in 2017. While TCM program interventions have been shown to reduce the average cost of care per episode for Medicare beneficiaries, there is speculation that widespread adoption has been hindered by lack of required infrastructure and challenges with scaling the services in many physician practices.[viii] This presents a potential opportunity for hospitals and health systems to collaborate with primary care physicians in an organized approach to better leverage this resource.

Successful Accountable Care Organizations (ACOs) have developed multidisciplinary teams for care coordination that promote *shared responsibility and accountability* among referring and receiving clinicians during all points of care transitions with clearly defined, standardized procedures and communication channels. This approach fosters collaboration, more effective handoffs, higher levels of engagement and compliance on the part of patients, and better outcomes from downstream care providers in other settings.

Under the ACO paradigm, financial and operational incentives are aligned, by design, to promote this level of collaboration and integration. As of 2016 only 14.7% of Medicare beneficiaries were enrolled in an ACO model and could potentially benefit from this approach.[ix] Hospitals and health systems that are not participating as ACOs may benefit from adopting interdisciplinary team best practices.

Summary

"At the heart of teamwork is communication, and at the heart of communication is LISTENING."

This quote is from an insightful article, "*Are You Listening…Are You Really Listening?"* which examines the common factors that contribute to communication breakdowns in health care.[x] As the family member of patient who was harmed by a preventable medical error, the author reflected on what happened: *"I think if people just stopped, just listened to what I was saying, listened to what my family was saying, good communication could have prevented everything that went wrong."*

More than detailed discharge instructions or standardized procedures, effective communication and collaboration with the patient and family are truly at the heart of better care transitions. Equipping patients with the right information and resources to support continuing care can improve both outcomes and the overall care experience.

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About the Authors

Patrick Lee, MHA, a principal consultant with Stamp&Chase, has more than 30 years of healthcare management and leadership experience in a range of organizations that include top academic healthcare institutions and specialty hospital companies. Starting his career in 1979 as a Registered Medical Technologist, he served in clinical laboratory management roles with St. Louis Children's Hospital, The Cleveland Clinic, and Barnes-Jewish Hospital overseeing cutting edge laboratory, blood bank, apheresis, and bone marrow processing/preservation program operations.

After receiving a Master's Degree in Healthcare Administration & Planning from Washington University School of Medicine in 1994, Patrick served in an executive leadership development role working directly with the CEO of BJC Healthcare during the early years following the initial formation of that integrated, 12-hospital system. Patrick subsequently served as corporate Vice President for Regional Affiliates & Network Development and executive liaison with BJC's 11 affiliated rural hospitals, where he helped to expand BJC's regional market penetration.

Patrick served as CEO for Howard Rusk Rehabilitation Center, a 60-bed acute inpatient rehabilitation hospital and a joint venture between University of Missouri Healthcare and HealthSouth, which operates as a teaching hospital for the University of Missouri School of Medicine. The hospital operated a specialty pediatric inpatient and outpatient rehabilitation unit, the only one of its kind in the region. Patrick served as Senior Vice President of Operations for Horizon Health, overseeing the contract management of more than 30 acute hospital-based inpatient rehabilitation programs in 15 states, working with hospital clients to establish new programs and optimize performance. In 2008, he formed a company with several partners specializing in the development, implementation and operation of specialty hospitals and healthcare services.

Patrick brings this range of experience and perspective on healthcare delivery across the continuum to Stamp&Chase in order to help clients raise the performance bar by developing practical strategies and enhanced communication competencies and practices in their organizations. He is proficient in strategic data analysis to translate quantifiable opportunity into specific pathways and metrics for program development and performance optimization.

Burl Stamp, FACHE, is the President/Founder of Stamp&Chase, Inc. With broad-based experience working alongside health care professionals from the boardroom to the bedside, Burl has helped major health systems, academic medical centers and community hospitals improve bottom line, patient experience, staff engagement and patient safety results.

Prior to launching Stamp&Chase over 14 years ago, Burl served several leading health care organizations in executive roles. As president and CEO of Phoenix Children's Hospital, he spearheaded development and construction of the first comprehensive, freestanding health care campus in Arizona dedicated to pediatrics. He developed the first strategic planning and marketing department at St. Louis Children's Hospital, where he started the highly successful Answer Line in 1989 to provide reliable, accessible health advice to families. He went on to lead pediatric services development for BJC Healthcare/Washington University Medical Center.

As the principal consultant to Ascension Health's Experience Team for over four years, Burl worked with a dedicated group of leaders within the country's largest not-for-profit health system to develop structured, sustainable approaches to consistently improving the patient experience across the system's 75+ hospitals.

Burl is the author of *The Healing Art of Communication*, a health care professional's guide to improving communication. He is a frequent speaker on communication, leadership, organizational culture and business development strategy in health care organizations.

About Stamp&Chase

Stamp&Chase partners with leading healthcare providers across the country to improve the care experience by improving communication competencies and practices among frontline caregivers and leaders. At the heart of the firm's work are two comprehensive sets of tools and strategies to support care teams:

CARE*munication*®

A comprehensive curriculum for frontline staff focused on building competencies and practices that improve communication with both patients and colleagues

A robust portfolio of mobile leader tools and approaches that sustain performance improvement through more effective manager coaching, goal-setting, mentoring and accountability

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