4 STEPS

to Maintain Communication after Discharge

By employing best practices before discharge and during care transitions, hospitals can reduce the risk of readmission penalties, shorten length of stay, enjoy improved efficiencies and support robust patient care.

ENSOcare®
— Care Coordination Solutions —

Cerner Post Acute Referrals®, powered by Ensocare content, is an add-on feature available within Cerner Acute Case Management. The solution automates the referral process to help case workers and discharge planners facilitate communication before, during and after discharge.

Visit www.ensocare.com/cerner

THE SITUATION

It's no secret that **engaging patients in their care** is essential to care quality, increasing patient satisfaction and, ultimately, achieving positive patient outcomes.

When the patient leaves the hospital, however, it can be a challenge to sustain patient engagement, especially when it comes to maintaining communication and overseeing care continuity.

QUESTION

What is the percentage of hospital-discharged patients admitted to post-acute care?

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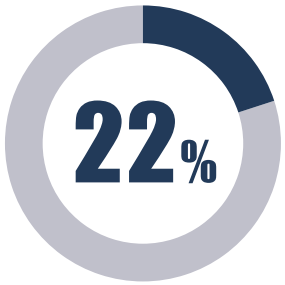
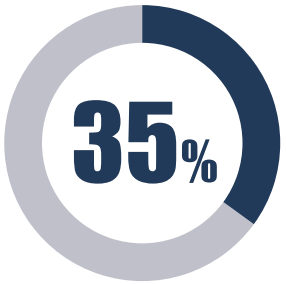
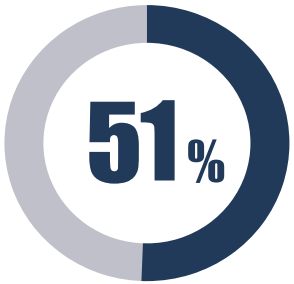
B. 

C. 

D. 

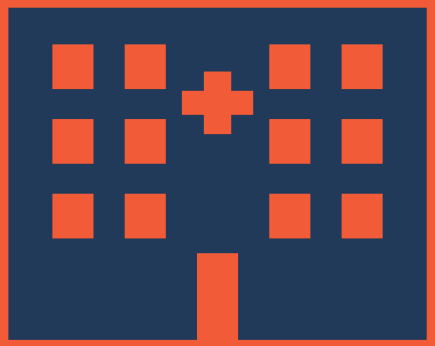
ANSWER

C.

Despite this high frequency, **hospitals and post-acute providers remain relatively disconnected from one another**, making patients and their families primarily responsible for following post-discharge care plans.

DID YOU KNOW?

Hospitals discharge **35.1 million patients** each year and must coordinate care with a vast post-acute system, including:



15,700+ skilled nursing facilities

12,200+ home health agencies

4,800+ adult day services centers

400+ long-term acute care hospitals

As such, **engaging patients and their support system** in post-acute care **is essential to the patient's recovery or chronic disease management** and **is key to limiting the potential for avoidable readmissions.**

Sources: Medicare Payment Advisory Commission. (June 2010). Data Book: Healthcare Spending and the Medicare Program. Washington, DC.
http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf *http://www.cdc.gov/nchs/fastats/hospital.htm*

LET'S DO THIS

Though patient and family engagement can be tough once a patient is "out of sight" and beyond your hospital's walls, **you can follow the steps outlined in this e-book to:**

- Facilitate communication
- Continue patient oversight
- Ensure patients follow their care plans

STEP 1

Help the Patient and Family Understand the Diagnosis

Whether an inpatient stay is the result of a sudden illness or a trip to the emergency room, patients typically don't expect to be in the hospital. They may be confused, surprised and emotional, on top of whatever ails them, and they may not fully accept or understand their condition.

THIS IS KEY:

A patient's understanding and acceptance of their condition is the foundation of their involvement in post-acute care.

Therefore, it is essential for hospital staff and physicians to communicate with the patient and his or her family about the diagnosis in an effective and timely manner.

RISKY BUSINESS

Without a clear understanding and acceptance of his/her care plan, a patient may:

- Forgo follow-up appointments
- Stray from dietary guidelines
- Stop taking prescriptions
- Decline therapeutic treatment

all of which can be detrimental to the patient's recovery or chronic disease management.

PATIENT HEALTH LITERACY

To determine a patient's understanding of and ability to manage health information, **hospitals should assess the patient's health literacy** and **readiness to learn** through **conversations** with the patient and family.

BY THE NUMBERS

Limited health literacy is estimated to cost

$106-$236 billion

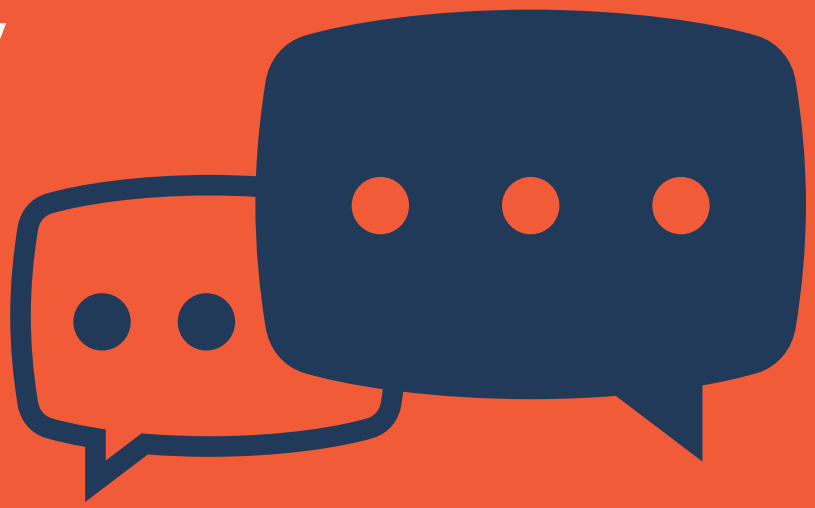
annually and is associated with poor health outcomes.

Source: http://www.nih.gov/clearcommunication/healthliteracy.htm

COMMUNICATION 101

It is important to **educate and communicate with patients in the most preferred and effective manner for them**, especially since they are likely to experience anxiety and be overwhelmed with new information.

- ✓ Don't assume the preferred language
- ✓ Ask what language is preferred
- ✓ Respect language preferences and use preferred method consistently



COMMUNICATION 101

Tailor teaching methods to the patient through:


One-on-one conversations


Phone calls


Emails


Printed literature


Videos


Web sites


Text messages

STEP 2

Ensure the Patient and Family are Committed to following the Care Plan

MANAGING ROLES AND EXPECTATIONS

Many patients need help following a care plan after discharge and rely on family members to manage prescriptions and other aspects of his/her health.

The family also plays a vital role in keeping the patient healthy by:

- Offering emotional support
- Relieving anxiety
- Reinforcing healthy decisions

For these reasons, it is important for the patient and caretakers to know:

- ✓ What the care plan includes
- ✓ What's expected of them

This will help **ensure the patient continues down the path of recovery** and **meets key milestones**, contributing to better outcomes.

EMPLOY THE TEACH-BACK METHOD

By using targeted communication and educational tools, hospitals can facilitate discussions with patients and families to ensure they know the next steps in the patient's care.

For example, **have patients and families demonstrate medication administration techniques or other self-administered treatments**. This confirms that all parties fully understand how to sustain treatment over time.

STEP 3

Keep the Patient and Family Actively Involved in Care Transitions

IT IMPACTS PATIENT SATISFACTION

In a time when patients and their families may feel helpless, urging them to be **directly involved in care decisions and transitions** is one way to **keep them engaged and empowered**—an important component of long-term patient satisfaction.

IMPROVE ENGAGEMENT WITH TECHNOLOGY

An effective way to involve patients in care transitions is to **leverage discharge and care coordination technology to connect patients with appropriate post-acute providers** while the patient is still in the hospital.

Automated solutions can streamline care transitions by conveniently delivering key information about post-acute providers, enabling patients and families to make informed decisions quickly and easily.

While manually arranging post-acute care transitions can take days, care coordination and discharge technology:

Helps hospitals:

- **Obtain responses from area providers in as little as 30 minutes**

— & —

Allows patients and family members to:

- Efficiently review care options
- Identify preferred providers
- Make choices without adding unnecessary days to a patient's stay and incurring added expenses

STEP 4

Leverage Technology to Continue Patient Oversight

DON'T STOP NOW

Patient engagement efforts shouldn't stop when patients leave the hospital.

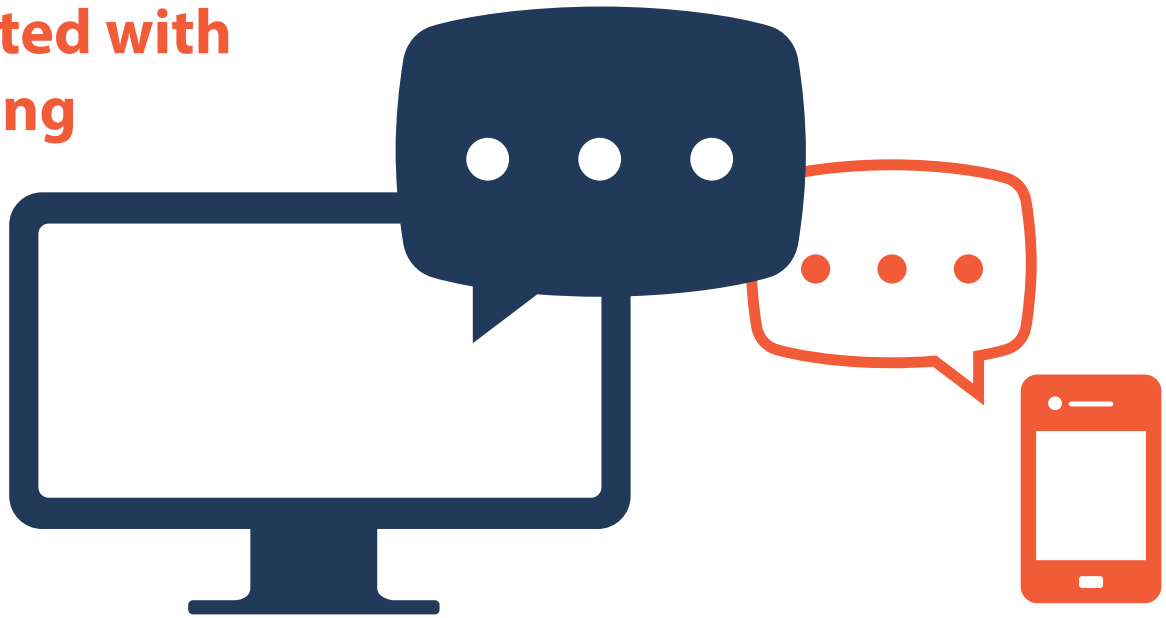
In fact, **the post-acute care setting is one of the most critical times to communicate with patients**, as they may forget care instructions or find it difficult to adapt to new demands or to change old habits.

Technology can make it easier for hospitals to keep patients, families—as well as providers—focused on the patient's care and working toward the same goal.

For example:

Care coordination and communication platforms offer support to patients and their families by **sending alerts and reminders,** and by **tracking recovery progress through compliant emails, text messages and other tools**.

This allows hospitals and providers to **stay virtually connected with their patients, monitoring progress** and **overseeing care long after discharge**.



THE BOTTOM LINE

Getting patients and their families actively engaged in and committed to their post-acute care can:

- ✓ Limit preventable readmissions
- ✓ Reduce overall health-care costs
- ✓ Improve patient outcomes

ABOUT THE AUTHOR

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Mary Kay Thalken brings more than 30 years of experience in health-care leadership to Ensocare. Prior to joining Ensocare, she served as Enterprise Vice President for Care Logistics in Atlanta, Ga. She has held executive leadership positions at hospitals in Nebraska and Iowa, including the position of Chief Nurse Executive and System Quality Executive for Alegent Health. Thalken has presented on the topics of improving quality, patient flow and throughput at various industry conferences and webinars. Thalken holds an MBA from the University of Nebraska at Omaha. She is a member of the American College of Healthcare Executives, American Organization of Nurse Executives and Heartland Healthcare Executives.

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ENSOcare®

— Care Coordination Solutions —

Automated discharge by Ensocare, embedded right inside Cerner Post Acute Referrals®, allows your staff to **work more efficiently so you can spend more time with patients.**

- Discharge case management
- Workflow **fully-embedded** into Cerner Acute Case Management®
- **100+** successful Cerner/ Ensocare implementations to date
- **24/7 live customer support** drives provider engagement and **median response time of less than 30 minutes**
- No-cost national post-acute network
- **Post-acute** clinical documentation sharing
- Direct and efficient **electronic notifications**

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