Patient discharge

information

Tools for success

By Debra Polster, MS, APN, CCRN, CCNS

PREVENTING HOSPITAL READMISSIONS is a national focus for health-care reform. Consequently, patient discharge education is increasingly important for improving clinical outcomes and reducing hospital costs.

How does a nursing intervention such as patient education impact patient outcomes and healthcare costs? According to the Centers for Medicare and Medicaid Services (CMS), nearly 20% of all Medicare patients are readmitted to the hospital within 30 days of discharge; 34% are readmitted within 90 days of discharge.[1]

In 2012, CMS began penalizing excess readmissions; these penalties add up to about 1% of Medicare payments. Almost two-thirds of U.S. hospitals paid the price in 2012. These fees have increased up to a limit of 3% of total Medicare compensation. Typically amounting to over $130,000 per penalized facility, these fees have focused more attention on the discharge process and ways to prevent hospital readmissions.[1] This article presents key educational tools essential for preparing patients to care for themselves at home, improving patient outcomes, and minimizing readmissions.

Reducing the risk of readmission

CMS expects nurses and other healthcare team members to address modifiable factors that can increase the chance of rehospitalization. These include:
- unplanned and early discharge or insufficient postdischarge support
- inadequate follow-up
- therapeutic mistakes
- adverse drug events and other medication-associated concerns
- failed handoffs
- complications after procedures
- patient falls, healthcare-associated infections, and pressure ulcers.[2]

Identifying patients at risk for readmission up front and collaborating with care managers and healthcare providers to minimize the risk are essential. As many as 79% of readmissions are considered preventable and a direct result of uncoordinated care.[2] The Joint Commission recommends

a multifaceted approach to prevent readmissions that includes explanations of discharge instructions, self-care, and ongoing or emergency care; inventory of outpatient resources/referrals; medication reconciliation; and understandable instructions for the patient and family. A patient-individualized approach noting preferred language, culture, and the patient's health literacy level is also recommended.[3] When planning any care transition, another term for discharges and transfers, clinicians should draw from a toolkit of effective patient education strategies and resources tailored to their patient population. (See *Meeting the standard of care for transitions*.)

Baseline assessment
The multifaceted discharge process begins on admission and continues throughout the hospital stay. The initial step is a baseline patient assessment, including an assessment of the patient's risk for readmission. Risk factors for readmission include clinical issues such as advanced chronic obstructive pulmonary disease (COPD), heart failure, stroke, diabetes, significant unintended weight loss, depression, cancer, and palliative care. Use of high-risk medications such as antibiotics, glucocorticoids, anticoagulants, opioids, antiepileptic drugs, antipsychotics, antidepressants, and hypoglycemic agents may also increase the likelihood of readmission. Other factors raising the risk include polypharmacy, previous hospitalization (unscheduled hospitalizations within the last 6 to 12 months), low health literacy level, black race, and lack of social support with inadequate or no family or friend contact by phone or in person.[4]

Identifying a patient's ability to perform self-care will help the nurse prepare the patient for discharge. According to Orem's Self-Care Deficit Theory, those who can't independently care for themselves and need help for everyday activities have a self-care deficit.[5] Other education challenges include the nurses' inability to identify those patient self-care deficits; for example, because of limits to the time the nurse can spend with the patient during the admission. These deficits may persist at discharge.[6] Patients who can't care for themselves will require additional resources, such as home healthcare services or physical therapy.

Dedicate time for assessments and discharge teaching. Effective patient teaching requires uninterrupted blocks of time. To support this, post signs outside the patient's room to indicate a "do not disturb zone." Hand off patient assignments so you can give the patient your undivided attention. Eliminate distractions, such as the television. Make sure the patient is wearing any sensory aids he or she normally uses, such as glasses or a hearing aid. (For more tips, see *Eye contact and other strategies*.)

Assessing health literacy
A critical patient history element is documentation of the patient's baseline knowledge and skills. Patient educational assessments should include health literacy, defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[7] A good way to evaluate health literacy is to ask patients to read their prescription containers and explain how they should take their medication.

Meeting the standard of care for transitions[21]

Transition of Care Consensus Conference (TOCCC) guidelines published in 2009 are based on a multistakeholder consensus conference that included physicians, nurses, pharmacists, and representatives of governmental agencies. This team recommended that at a minimum, the following data should be included in the transition record:

- principle diagnosis and problem list
- medication list (reconciliation) including over-the-counter medications/herbals, allergies, and drug interactions
- patient's medical home or the transferring coordinating healthcare provider/facility and contact information
- patient's cognitive status
- test results/pending results.

    Ideally, the transition record should also contain additional details, such as:

- emergency plan, contact person, and contact number
- treatment and diagnostic plan
- prognosis and goals of care
- advance directives, power of attorney, and informed consent
- planned interventions, such as wound care
- caregiver status.

    The TOCCC report recommends that patients and their families/caregivers receive and understand the transfer record and be encouraged to participate in its development. All communications between patients, family, and caregivers must be secure and private, in compliance with the Health Insurance Portability and Accountability Act.

An important component of health literacy is reading ability (literacy). This can be defined as the ability to read, write, and speak proficiently enough to function in society and at work.[7] A patient's ability to read instructions and educational materials directly affects the patient's ability to adhere to the medication regimen and treatment plan. This is a challenging health issue for prescribers caring for patients with low literacy skills.[3]

A common misperception of a patient with low literacy is the assumption that the patient is deliberately nonadherent with the health plan. Never forget that a patient's inadequate communication skills may not mean resistance to the treatment plan or poor intellect, but rather a low skill level. People with low literacy skills may have the capability to build up these skills but haven't had the chance to do so for any number of reasons.[8]

Determining reading level and readability

All education materials should include a determination of literacy level. Various formulas are available to ascertain the patient's reading grade level based on such factors as sentence length and word difficulty.

Keep in mind that the grade level a patient completed in school isn't necessarily a good indicator of reading ability. Rather than asking about years of formal education, use a validated assessment tool to assess literacy. For example, The Newest Vital Sign is a fast and precise bilingual (English and Spanish) screening test for general literacy, numeracy, and comprehension skills applied to health information.[9] Numeracy (math) skills are needed for many health-related activities, such as measuring medications, reading food labels, and choosing

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Eye contact and other strategies[4]

AHRQ offers these suggestions for establishing and maintaining rapport with the patient during education sessions:

• offer a warm greeting
• establish eye contact
• slow down
• use plain, nonmedical words
• limit content
• use the teach-back technique
• repeat key points
• involve the patient, family, and significant others (with the patient's permission)
• use visual displays to reinforce information.

Practice effective communication strategies with colleagues, family, and friends. With regular practice, application to daily patient use will become easier each day.

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among health plans with differing premiums, copays, and deductibles.[10] This tool is intended for use in primary care settings.

The Single Item Literacy Screener has also been found to have good sensitivity for evaluating a patient's literacy and reading skills when weighed against other validated tools.[11] To use it, the nurse asks one question: "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?" The patient chooses an answer from *never* (1) to *always* (5). A score of 2 or more suggests a need for literacy assistance.[9]

Patient education websites, printouts, animations, and more can be used at the bedside to help educate patients with low literacy skills. Printed materials should be prepared at the appropriate literacy level and visual aids tailored to the patient's medical condition and needs.

As a general rule, patient education materials should be written at the eighth grade level or lower.[8] Keep in mind, however, that an appropriate reading level is only one component of an effective patient education tool.

Visual enhancements

Understanding how adults learn can help you tailor education to a patient's advantage. (See *Consider the patient's learning style*.) For example, one patient may learn best from reading printed instructions; another may prefer to watch a demonstration. Blending elements from multiple adult learning styles increases the likelihood that patients will remember essential information.

Most people are visual learners, so educational visual aids enhance understanding and encourage adherence to a treatment plan. Use of visuals with animations or handouts can be helpful. Large fonts, colorful pictures, adequate white space on the page, and key points that are bulleted for emphasis are all essential components. The use of nonprinted educational materials such as video and audiotapes, demonstrations, models, pictograms, and other visuals are other options.

Role-playing instructions and simulation with the patient and family can also be a valuable strategy for patient learning. Work with props and real equipment when indicated. For example, use crutches when explaining how to use them correctly, or a real wound dressing when teaching about

wound care. Including the appropriate learning style will increase the likelihood that patients will remember the essential information presented.[9]

Cultural competence

Cultural competence also influences the nurse's ability to communicate meaningfully with the patient. Cultural competence allows the nurse to deliver care in a way that's considerate of and responsive to the patient's health beliefs, practices, and culture.

According to the National Institutes of Health, "culture is often described as the combination of a body of knowledge, a body of belief and a body of behavior. It involves a number of elements, including personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social groups."[12] The nurse should note these elements that influence a patient's beliefs about health, healing, wellness, illness, disease, and delivery of health services.

With mounting concern for racial, ethnic, and language disparities in healthcare and the call for healthcare systems to support ever more diverse patient populations, language access services have become increasingly a matter of national importance. All

To build rapport with the patient, begin teaching sessions by offering a warm greeting and establishing eye contact.

nurses who are responsible for patient education should take part in formal education in cross-cultural healthcare to develop a full appreciation of how culture and language influence healthcare.[12] Even bicultural and bilingual nurses will be prompted to serve patients with cultural and language preferences that are different from their own. Nurses should work toward cultivating cultural self-awareness, avoid making assumptions about patients' needs, and be receptive to learning from the patients themselves.

Plain talk about communication

According to The Joint Commission, clear and effective communication is a cornerstone of patient safety.[13] When explaining a condition or treatment, use plain language to communicate as clearly as possible. The message can get lost in translation when nurses use medical terminology that patients don't understand. Examples of communicating in plain language include using simple or everyday language instead of medical or nursing jargon, breaking down complex information into smaller chunks, and speaking directly to the patient using active (not passive) voice.[7]

When talking with the patient, speak slowly. Focus on the most significant "must know" information, using the least amount of information possible. Always provide the most essential information either first or last, making important points clear. Review, clarify, and reteach as necessary.[3]

Encouraging patients to ask questions helps the nurse assess how well the patient understands the information being taught. According to the Agency for Healthcare Research and Quality (AHRQ), patients can feel embarrassed to ask questions or may not even know what questions they need to ask.[4] Listed below are a few tips from AHRQ for promoting questions throughout your patient encounters:

• Don't appear rushed. Patients are reluctant to ask questions if they think nurses are too busy to talk with them.
• Tell patients that you expect questions. For example, you could say,

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Consider the patient's learning style[19,20]

Adult learners respond best to an educational approach that suits their learning style, which can be defined as an approach to learning based on individual strengths, weaknesses, and preferences. Although many people have one preferred learning style, they benefit most from teaching that incorporates several other styles as well. Learning styles can be categorized as follows:

• verbal—written or spoken words
• visual—pictures, images
• aural—sounds, music
• physical (kinesthetic)—sense of touch
• logical—reasoning, systems
• social—a preference for learning in groups
• solitary—a preference for self-study, working alone.

"That was a lot of information. I'm sure you must have questions."

• Avoid asking a yes-or-no question, such as, "Do you have any questions?" Patients often say no even if they do have questions.

• Listen without interrupting. Questions may emerge as the patient talks.

• Encourage family members to ask questions too.[4]

The Ask Me 3 patient education program was created by the National Patient Safety Foundation to help encourage effective communication between patients and care providers with the goal of increasing patient comprehension.[14] This program prompts patients to ask about three things before ending an encounter with a healthcare professional: *What is my main problem? What do I need to do? Why is it important for me to do this?* The National Patient Safety Foundation recommends encouraging patients to ask as many questions as necessary for complete comprehension.

Another tool, the AHRQ's "Questions Are the Answer" campaign, builds on 10 basic questions to promote better communication between patients and their healthcare team.[15] Using the AHRQ's "question builder" tool, patients can focus and individualize these basic questions to learn more about their medications, diagnostic studies, and recommended treatments. Creating an inventory of individualized questions can empower patients by helping them get the information they need to make educated choices about their healthcare.

Learn the teach-back technique

Also known as the "show-me" method, the teach-back technique is one of the simplest ways to bridge the communication gap between nurse and patient.[9] It's intended to help the nurse verify the patient's understanding of new knowledge and skills. An

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important point to remember is that teach-back isn't a test of the patient's knowledge; it's a way to confirm that you've explained what the patient needs to know in a way that the patient understands. This process can also help staff members learn which descriptions and communication techniques work best with their patients.

From the North Carolina Program on Health Literacy, here are a few suggestions for using teach-back in a patient teaching session.

• "I want to be sure that I explained your medication correctly. Can you tell me how you are going to take this medicine?"

• "We covered a lot today about your diabetes, and I want to make sure that I explained things clearly. So let's review what we discussed. What are three strategies that will help you control your diabetes?"[9]

Documentation

Accurate and timely documentation in the electronic health record should reflect evaluation of knowledge and skills taught and learned and demonstrated by the patient in return. Documentation should include the patient's preferred learning style, barriers identified, such as low literacy skills or limited financial support, preparedness to learn, and relevant clinical information such as a new diagnosis or poorly managed pain. Resources and support available at home should be recorded with perceived barriers, interventions to overcome barriers, and outcome achieved.

Application to chronic diseases

One of the most common diseases that require rehospitalization within 30 days of discharge is COPD. Patient teaching during stable periods is recommended to educate patients about self-care. Many of patients with COPD rely on self-taught self-management strategies during exacerbations that they may not report. This suggests that clinicians should give more comprehensive education; for example, teaching patients about triggers to avoid, signs and symptoms of exacerbations, strategies to manage exacerbations, and information about medications. When nurses simplify treatment regimens and verify patient knowledge and skill with new inhalers, patients are better able to self-manage their treatment and prevent exacerbations.

Another common chronic disease requiring in-depth education is diabetes. The American Diabetes Association (ADA) *Standards of Medical Care in Diabetes* provides clear guidelines for discharge planning and self-management education.[16] The ADA's revised recommendations published in 2015 reinforce the importance of diabetes education: "People with diabetes should receive diabetes

self-management education (DSME) and diabetes self-management support (DSMS) according to the national standards for DSME and DSMS when their diabetes is diagnosed and as needed thereafter."[17]

In an effort to improve self-management of diabetes care, discharge plans should include at minimum:

• medication reconciliation. To ensure continuity of the medication regimen, patient's medications must be verified to be sure no chronic medications were discontinued and to ensure the safety of new prescriptions. Ideally, prescriptions for new or updated medications should be filled and discussed with the patient and family at or before discharge from the hospital.

• structured discharge communication. Information on medication updates, lab tests and procedures, and follow-up requirements must be precisely and promptly communicated to outpatient providers, including the primary care provider. When the inpatient healthcare providers schedule follow-up visits before discharge, the appointments are more likely to be kept.

Outcome assessment
Metrics including readmission rates for patients at high risk for COPD exacerbations, acute myocardial infarction, pneumonia, and heart failure should be monitored to determine education program success. Patient satisfaction scores for printed discharge instructions may also reflect a practice change. Ultimately, assessment and evaluation of the patient's new knowledge and skills is the primary goal of education.

Outcome evaluation can also be determined in postdischarge phone calls. Many hospitals have developed call centers to ensure follow-up phone calls are consistently made. A phone call may reveal that the patient needs additional support at home. Follow-up visits with healthcare providers may provide additional support when indicated.

The literature notes a correlation between improved nurse knowledge and improved patient knowledge.[18] Nurses should seek additional resources to build their teaching skills. (For examples, see *Patient education resources*.)

Set patients up for success
To demonstrate that they've learned the information and skills necessary for self-care, patients should be able to verbalize and demonstrate vital self-care measures. Literacy,

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Patient education resources

• Agency for Healthcare Research and Quality. Reengineered discharge (RED) toolkit.
http://www.ahrq.gov/professionals/systems/hospital/toolkit/index.html.

• Agency for Healthcare Research and Quality. The patient education materials assessment tool (PEMAT) and user's guide.
http://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/pemat/index.html.

• American Medical Association. Health literacy resources.
http://www.ama-assn.org/ama/pub/about-ama/ama-foundation/our-programs/public-health/health-literacy-program/health-literacy-kit.page.

• Center for Medicare Education. Writing easy-to-read materials.
http://medicine.osu.edu/sitetool/sites/pdfs/ahecpublic/Writing_easytoread_materials.pdf.

• Centers for Disease Control and Prevention. Plain language thesaurus for health communications.
https://depts.washington.edu/respcare/public/info/Plain_Language_Thesaurus_for_Health_Communications.pdf.

• Centers for Disease Control and Prevention. Simply put: a guide for creating easy-to-understand materials.
http://www.cdc.gov/healthliteracy/pdf/Simply_Put.pdf.

• Centers for Medicare and Medicaid Services. QIO Program: Integrating care for populations and communities.
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/Downloads/QIOIntegrateCare-.pdf.

• Health Resources and Services Administration. Health literacy.
http://www.hrsa.gov/publichealth/healthliteracy.

• Management Sciences for Health. The provider's guide to quality and culture.
http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English.

• National Patient Safety Foundation. Ask Me 3.
http://www.npsf.org/?page=askme3.

• North Carolina Program on Health Literacy. Tips for communicating clearly.
http://www.nchealthliteracy.org/toolkit/tool4.pdf.

• Society of Hospital Medicine. Project BOOST mentored implementation program.
http://www.hospitalmedicine.org/BOOST.

• The Institute for Healthcare Improvement. http://www.ihi.org.

• The National Transitions of Care Coalition. http://www.ntocc.org.

• U.S. Department of Health and Human Services. Think cultural health.
https://www.thinkculturalhealth.hhs.gov.

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cognition, education level, socioeconomic status, and level of social support all contribute to a patient's adherence to printed discharge instructions. Careful attention to providing an individualized plan of care will set up the patient for success. A well-orchestrated team of nurses, healthcare providers, therapists, pharmacists, respiratory care providers, dietitians, and care managers can reduce readmissions, improve the patient experience, and enhance the patient's quality of life. ■

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