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Rehabilitation Practitioners' Prioritized Care Processes in Hip Fracture Post-Acute Care

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Abstract

Aims—Occupational and physical therapy in post-acute care (PAC) has reached the point where quality indicators for hip fracture are needed. This study characterizes the practitioners' prioritized hip fracture rehabilitation practices, which can guide future quality improvement initiatives.

Methods—Ninety-two practitioners participating in a parent mixed methods study were asked to rank a series of evidence-based best practices across five clinical domains (assessment, intervention, discharge planning, caregiver training and patient education).

Results—Prioritized practices reflected patient-practitioner collaboration, facilitating an effective discharge, and preventing adverse events. The highest endorsed care processes include: developing meaningful goals with patient input (84%) in assessment, using assistive devices in intervention (75%) and patient education (65%), engaging the patient and caregiver (50%) in discharge planning, and fall prevention (60%) in caregiver education.

Conclusions—Practitioners identified key care priorities. This study lays the foundation for future work evaluating the extent to which these practices are delivered in PAC.

Keywords

hip fracture; rehabilitation; post-acute care

Introduction

Since the enactment of the Affordable Care Act (ACA), the healthcare system has been transitioning from a fee-for-service to a value-based reimbursement model. Post-acute care (PAC) rehabilitation reimbursement has historically been driven by intensity (e.g., minutes of therapy) rather than quality of care and outcomes. However, the transition to value-based payment introduces a new approach, which incentivizes improving patient outcomes by using evidence-based, patient-oriented care (i.e. high-quality care), by linking payment with

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the performance of the care provider (Honore et al., 2011; Berwick, Nolan, & Whittington, 2008; Honore et al., 2011). Unfortunately, not only are existing clinical guidelines that aim to characterize high quality PAC hip fracture rehabilitation insufficient, very few have outlined the cumulative treatment practices that constitute an episode of care. This renders rehabilitation providers ill-equipped to methodically enhance patient outcomes or engage in systematic quality improvement initiatives. With rehabilitation being an integral part of a patient's recovery process and PAC being the driver of raising healthcare costs, there is a need to classify what comprises high-quality care and its association to outcomes to enable rehabilitation to thrive in the healthcare reform framework (Leland et al., 2015; MaCurdy et al., 2013).

Hip fracture patients, who use a broad range of rehabilitation services, historically have had poor outcomes and therefore are a critical patient population in need of quality improvement initiatives. Specifically, patients experiencing a hip fracture have an increased risk of mortality, morbidity, hospital readmissions due to failed community transitions, and long-term institutionalization (Klop et al., 2016; Leland et al., 2015; Haleem et al., 2008; Parker et al., 2006; Berry et al., 2008; Haentjens et al., 2003; Lyles et al., 2008; van Helden et al., 2007). Furthermore, this patient population has a high risk of additional falls and fractures, which often result in subsequent hospital readmissions, institutionalization, and functional decline (Ryg et al., 2009; Huntjens et al., 2010). The implementation of better practices in hip fracture rehabilitation would decrease the risk of these negative health outcomes.

In the United States, 90% of Medicare patients recovering from hip fracture are transferred to a PAC facility after staying in a hospital for an average of six days (Gage et al., 2011; Buntin et al., 2010). Rather than returning home and receiving home health care or being transferred to an inpatient rehabilitation facility, a majority of these patients receive PAC in a skilled nursing facility (Leland et al., 2015; Nguyen-Oghalai et al., 2008). Unfortunately, adverse outcomes that include falls with injury and readmissions are prevalent in this patient population, thereby increasing the patient's risk of morbidity, mortality, and institutionalization, thereby limiting the possibility of achieving desired outcomes (Leland et al., 2015).

There is strong evidence that supports the effectiveness of interventions for hip fracture recovery (Beaupre et al., 2013; Handoll et al., 2011; Colon-Emeric et al., 2012; Crotty et al., 2010). However, there are few clinical guidelines that outline the cumulative rehabilitation practices in PAC that are critical for optimizing patient outcomes after hip fracture (Buntin et al., 2010). This leaves occupational and physical therapy practitioners ill-equipped to engage in quality improvement interventions that lead to better outcomes after hip fracture. Given the pervasive poor patient outcomes in this patient population and the increasing emphasis on the provision of high quality care to enhance patient outcomes in the US, this void in the literature needs to be addressed (Beaupre et al., 2013; Beaupre et al., 2015).

Therefore, there is a need to characterize what constitutes high quality rehabilitation. Specifically, stakeholder-driven indicators could be an efficient way to assess the quality of PAC rehabilitation and inform quality improvement initiatives. Thus, we aim to rectify this critical gap by quantifying the perceptions of best practices in hip fracture PAC by frontline

clinicians delivering the interventions—specifically, those in physical and occupational therapy. These measures will contribute to the standardization of a mixed methods approach for assessing the quality of PAC rehabilitation.

Methods

Design

This study is a secondary-analysis of a subset of data collected as part of a larger mixed method study, which examined rehabilitation practitioners perspectives of best practices for hip fracture rehabilitation (Leland et al., 2017). In the parent study, occupational and physical therapy practitioners working in skilled nursing facilities participated in focus groups, which qualitatively explored best practices for hip fracture rehabilitation. In order to clearly and distinctly identify care processes that made up these best practices, at the end of each focus group session, participants were given a list of evidence-based care processes and asked to select the top five evidence-based care processes for each of the five clinical domains (assessment, intervention, discharge planning, caregiver training and patient education) that they prioritized as reflecting best practice. This manuscript presents the quantitative findings of the participants' prioritization of these discrete care processes.

Sampling and recruitment

Purposive sampling of PAC facilities in Los Angeles County was conducted to ensure variation in organizations, staff, and patients. The facilities varied in regards to primary organizational structure (e.g., staffing levels, number of beds) and case mix of patients (e.g., socioeconomic status, medical severity) that have been related to care quality (Gozalo et al., 2015, Leland et al., 2012, Mor et al., 2004, Castle et al., 2008, Castle et al., 2011). Sample selection originated from the Medicare Nursing Home Compare website—a government-run site that makes information regarding organizational and care qualities of facilities funded by Medicare and Medicaid payments in the US publicly available (<https://data.medicare.gov/data/nursing-home-compare>).

The study sample was comprised of occupational and physical therapy practitioners from 11 skilled nursing facilities, generated by purposive sampling from the Medicare website. It is important to note that the sample size for this study (n=92) differs from that of the parent study (n=99) due to the inability to obtain responses by some therapists who had to tend to pertinent patient responsibilities.

Data Collection

Therapists were instructed to complete a brief demographic survey that detailed their age (in years), gender (male or female), race (Asian, Black, White, or Other), type of provider (occupational therapy practitioner or physical therapy practitioner), years of experience, years working in their currently employed facility, and status as a full-time employee (yes or no).

The evidence-based care processes that were given to the clinicians to prioritize had been identified through a review of the literature, which examined five domains: Assessments

process, intervention implementation, discharge planning, caregiver training and education, and patient education. The practitioners' highest prioritized care processes within the five domains were ranked.

The assessments domain is characterized by the initial evaluation of a patient's abilities, limitations, prior functional abilities, goals of care, and risk factors when admitted into a post-acute care facility. Obtaining comprehensive knowledge about a hip fracture patient and their prerequisites is important in order to implement the most appropriate care (Olsson et al., 2007). There were 12 care processes included in this domain and comprised of fall risk screening, balance and psychological assessments, and identifying the patient as well as the caregiver's desired outcomes for the patient (SIGN, 2009; Singh, 2014). Psychological factors, such as fear of falling, are prevalent among hip fracture patients in rehabilitation and greatly increase patients' risk of subsequent future falls (Visschedijk et al., 2014). Therefore, assessing a hip fracture patient's fall risk and level of fear of falling is important in providing the most effective interventions to combat his or her fear (Oude et al., 2006).

The intervention domain consists of 21 evidence-based care processes that encompass effective interventions for hip fracture rehabilitation. According to the literature, interventions that are important in the process of hip fracture rehabilitation include activities of daily living (ADL) retraining, muscle-strengthening and balance exercise interventions, training in the use of assistive devices and equipment, coping strategies for fear of falling, and nutrition management (Portegijs et al., 2008; Singh et al., 2011; HersHKovitz et al., 2007).

The discharge-planning domain captures the components of hip fracture rehabilitation that aim to facilitate a safe and effective community transition. The 19 care processes in this domain reflect the concepts home/environment assessments and modifications, equipping the patient and caregiver with knowledge and skills to manage care needs after discharge, ensuring both the patient and caregiver understand the importance of the information provided, and the engagement of the patient and caregiver in planning for the care transition. These evidence-based care processes capture the caregiver-patient-practitioner collaboration that is needed in the discharge planning process, as well as ensuring the caregiver is well equipped to handle all caregiving responsibilities post discharge (Chen et al., 2015; Mackenzie et al., 2007; Lawler et al., 2015; Dowswell et al., 2000).

Both the caregiver training and patient education domains capture the importance of ensuring that the caregiver and patient have the necessary skills and knowledge for a safe transition back home, which is congruent with the more recent extensive care transition literature (Coleman et al., 2006; Naylor et al., 2013; Naylor et al., 2004). Among the 28 care processes in the caregiver training domain and the 27 processes in the patient education domain, some of the care processes are listed in both these domains due to their complimentary constructs, such as fall prevention and the use of assisted devices and equipment (Chen et al., 2015; Mackenzie et al., 2007; Lawler et al., 2015; Dowswell et al., 2000; Naylor et al., 2004).

Data Analysis

The total number of endorsements for each evidence-based care processes was calculated and divided by the total number of participants (n=92). After the frequency of endorsement for each process was calculated and ranked, those that received at least 50% endorsement were examined to identify themes and subthemes across care processes within and across domains. Themes across responses were identified using expert assessment and regrouped based on common characteristics.

Results

Table 1 presents the characteristics of the 92 practitioners who participated in the study. Occupational therapy (OT) practitioners made up 49.5% and physical therapy (PT) practitioners made up 50.5%. The average age of the practitioners was 38.3 and 67.6% of them were female. Participants consisted of 43.1% Asians, 2% Blacks, 41.2% Whites, and 7.8% identified as other or had selected more than one race. The participants had 10.7 average years (SD 10.3) of experience and 2.9 average years (SD 3.2) of working in their currently employed facility.

Assessment Domain

Table 2 presents the highest endorsed care processes in the assessment domain. Among the 12 initial set of care processes presented to the participants, five received at least 50% endorsement. The development of meaningful and achievable goals that were aligned with patient and caregiver preferences was endorsed by 84%. The assessment of caregiver and patient needs, knowledge, and viewpoints was endorsed by 78%. The account for the patient's precautions and medical history in care planning was supported by 77% and the identification of the patient's desired outcomes was 59%. Screening for fall risk was endorsed by 55%.

Intervention Domain

The intervention domain captures the therapists' focus on the services that are integrated throughout the PAC stay and target improvement in a patient's functional capacity. Among the 21 initial set of care processes presented to the participants, Table 2 presents the four care processes that were endorsed by at least half of the study participants. They were the use of assistive devices and equipment (75%), activities of daily living (ADL) retraining (63%), proper body mechanics to reduce injuries (59%), and a muscle strengthening exercise program (50%).

Discharge Planning Domain

The discharge planning domain is characterized by care processes that are critical in enabling a patient to return home and stay home after a PAC stay. Among the 19 initial set of care processes presented to the participants, Table 2 presents the three care processes that received at least 50% endorsement. They were to engage the patient and caregiver in discharge planning (57%), to provide information on purchasing assistive devices and equipment (55%), and to conduct home and environment assessments and modifications (54%).

Caregiver and Patient Training and Education

Caregiver and patient training and education were presented to participants as two separate domains. However, focus group participants prioritized the same care processes for both patients and caregivers. Among the 28 and 27 initial sets of care processes presented to the participants from the caregiver and patient domains, respectively, four from each received at least 50% endorsement. Table 3 shows that fall prevention received 60% from the caregiver domain and 62% from the patient domain. The use of assistive devices and equipment received 55% and 65% from the caregiver training and patient education domains, respectively. Training the caregiver about patient-related home care knowledge (54%, 65%) and training the caregiver and patient on the balance between patient autonomy, as well as abilities and inabilities (51%, 62%) were the highest endorsed care processes for the caregiver training and patient education domains, respectively.

The recurrent themes from the chosen care processes in all domains suggest the importance of high quality patient care and safe care transitions from the PAC facility back to the community. All care practices that were highest endorsed resonate the care practitioners' beliefs that PAC rehabilitation provided to hip fracture patients should encompass care that not only promotes optimal recovery, but also encourages both patient and caregiver to be well-equipped to make a smooth transition home and stay home by avoiding the possible risk factors that could result in hospital readmission.

Discussion

By identifying rehabilitation practitioners' perspectives on prioritized care practices that comprise high quality hip fracture PAC, this study addresses a critical deficiency in the literature. Although existing literature has focused on single rehabilitation interventions or recognized the significant role occupational and physical therapists play in postoperative multidisciplinary care, there is insufficient evidence depicting the constellation of interventions that make up a PAC rehabilitation stay (Beaupre et al., 2013; Handoll et al., 2011; Colon-Emeric et al., 2012; Chudyk et al., 2009; Crotty et al., 2010). The intent of quantifying the highest endorsed care processes in each of the five clinical domains (assessments, interventions, discharge planning, caregiver training, and patient education) was to capture PAC practitioners' perspectives of the core practices (i.e., minimum set of practices that should be delivered) during an episode of hip fracture rehabilitation.

The data results show that the primary goal of rehabilitation care for hip fracture patients is safely getting them home and ensuring that they are able to stay home. For example, from the assessment domain, accounting for the patient's precautions and medical history during the plan of care and screening for their fall risk contribute to the achievement of getting the patient to make a safe transition home. In regards to the intervention and discharge planning domains, retraining the patient on ADLs, strengthening their muscles through an exercise program, and performing assessments and modifications to their home environment, all support safe care transitions, as well as ensure that their home is void of any risks that could lead to hospital readmissions. These themes are further resonated by the highest endorsed care practices in the caregiver and patient training and education domains, such as fall prevention and the education of both the caregiver and patient on home care knowledge.

This finding is consistent with the parent study's qualitative themes that emerged on the objective of care (Leland et al., under review). However, this construct of successful rehabilitation is not reflected in the historically used research measure for community discharge, which relied on over-simplistic outcomes of either the patient returning back to the community or not (Reistetter et al., 2010). In the new paradigm of outcome-oriented patient care, higher priority needs to be placed on a broader number of measures that capture patients' functional ability, including getting home and staying home, also referred to as successful community discharge (Leland, 2015). The results of our study show that practitioners' perceptions of what constitutes high quality hip fracture PAC is congruent with the motive of legislation in the US, which delineates community discharge as getting the patient home and staying home (Congress, 2014).

The assessment domain practices encompass the initial assessment of the hip fracture patient, which then guides the development of the plan of care. The two highest endorsed care processes were developing meaningful and achievable goals with the patient and caregiver and assessing caregiver and patient care needs, knowledge, and viewpoints. These findings show that therapists realize the importance of the patient's context and goals and value a patient-driven, goal-oriented rehabilitation process (Turner et al., 2008). Capturing a holistic picture of the patient's medical status, precautions, and medical history was essential for care planning as well as identifying the patient's desired outcomes. The high endorsement of these practices reinforces the importance of the practitioner-patient-caregiver collaboration in developing the goals and plan of care (Wood et al., 2010). The prioritization of fall risk screening is consistent with previous studies that have shown that subsequent falls after hip fracture are common and often result in adverse outcomes such as death, morbidity, and long-term institutionalization (Visschedijk et al., 2014).

Improving the patient's function, mobility, and strength in order to facilitate achievement of the patient's desired goals were the core practices identified in the interventions domain. The highest endorsed care processes were the use of assistive devices and equipment, ADL retraining, proper body mechanics to reduce injuries, and the provision of muscle strengthening exercises. According to Hauer et al. 2002, strength training through exercises can greatly benefit geriatric patients in rehabilitation after hip fracture by reducing their risk of future falls. Assistive devices and equipment are commonly used to mitigate the difficulty of performing ADLs and transfers (Koval et al., 2000). Training on proper body mechanics and ADL retraining are essential for preventing future falls and injuries (Hoeman, 2008). These endorsed care processes highlight the need to support patient functional recovery and enhance body mechanics, as well as incorporate muscle-strengthening exercises (specifically from the PT perspective) and compensatory strategies with the use of adaptive equipment (Portegijs et al., 2008).

The prioritized discharge planning practices emphasize a patient-centered approach, which is to engage the patient and caregiver in the planning process, to provide information on purchasing assistive devices and equipment, and to conduct home and environment assessments and modifications in order to optimize the patients functional abilities within their own environment and to lower the risk of adverse events such as falls. This approach corresponds with findings from previous literature, which has identified caregivers'

impressions of being detached from discharge planning and being unprepared to handle caregiving responsibilities after discharge (Chen et al., 2015; Mackenzie et al., 2007; Lawler et al., 2015; Dowswell et al., 2000). These practices reflect the necessity to equip caregivers and patients with the skills that are imperative for a safe community care transition, which coincides with the more extensive literature on care transitions that has developed over the past decade (Coleman et al., 2006; Naylor et al., 2013; Naylor et al., 2004). Moreover, these care processes encompass the overarching goal of rehabilitation, which is to foster a successful community discharge, which for hip fracture patients includes preventing future falls and adverse events in the home that could send the hip fracture patient back to the hospital or result in long-term institutionalization (Gallagher et al., 2001). There is strong evidence that home and environmental assessments and modifications, as well as training patients to use of assistive devices (e.g. walkers and canes), can be effective in reducing the risk of falls in this patient population (Karinkanta et al., 2010; Johnston et al., 2010; Health Quality Ontario, 2008). In fact, one study showed that a single home visit by an occupational therapy practitioner, who conducted a standard home assessment and appropriate modifications to prevent falls, significantly decreased fall risk in a sample of ninety-five older adult women with hip fracture (Monaco et al., 2008). The caregiver training and patient education domains constitute the knowledge and training needed by both the caregiver and patient to ensure a safe community care transition (Coleman et al., 2006; Naylor et al., 2013; Naylor et al., 2004). Across these two domains, fall prevention, use of assistive devices and equipment, training the caregiver about patient-related home care knowledge, and training both groups on the balance between patients' autonomy, abilities and inabilities were the most highly endorsed practices. These four core concepts reemphasize importance of working with the patient and caregiver throughout the stay to reinforce skills and prepare them for discharge back into the community. The consistency of the results show that these endorsed processes resonate in each of the other three domains, essentially highlighting the goal of getting the patient home and ensuring that they are able to stay home (Congress US, 2015).

Limitations

This study involved focus groups from a limited number of skilled nursing facilities in Southern California, which may limit generalizability to other geographic regions and PAC settings (e.g., inpatient rehabilitation facilities). The data for this quantitative analysis was drawn from a larger mixed method study. Thus, ranked care processes could not be matched with individual participants characteristics. Care process priorities were limited to a predefined list of evidence-based practices that were pulled from the literature. Care processes presented to the participants were pulled from the literature but did not result from a systematic review of the literature. Thus, some practices may have been excluded. Despite these limitations, this study captures a critical perspective of the frontline PAC practitioner, which can inform subsequent quality improvement research.

Conclusion

This study captured PAC practitioners' prioritized evidence-based care processes for hip fracture rehabilitation. The care processes that emerged align with current healthcare reform

initiatives, which emphasize patient-centered high quality care and safe care transitions. These findings lay the foundation for future work evaluating the extent to which these care processes are delivered, endorsed by other stakeholders, and associated with patient outcomes.

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Table 1
Participant Characteristics

Variable	Rehabilitation Providers <i>n</i> = 92
Age, mean, (SD)	38.3 (9.2)
Female, %	67.6
Race, %	
Asian	42.4
Black	2.0
White	41.4
Other ^a	14.2
Type of Provider, %	
Occupational therapy practitioner	49.5
Physical therapy practitioner	50.5
Years of experience, mean, (SD)	10.7 (10.3)
Years working in the facility, mean, (SD)	2.9(3.2)
Full-time employee, % ^b	89.9

^a Other = participants who identified as other and participants who selected more than one race.

^b Full time employee = yes was a full time employee.

Table 2
Distribution of Highest Endorsed Care Process for Assessment, Intervention, and Discharge Planning

Distribution of Endorsed Assessment Care Processes	(%)
Develop meaningful goals with patient and caregiver input	84%
Assess caregiver and patient needs, knowledge, viewpoints	78%
Account for the patient's precautions and medical history during care planning	77%
Identify the patient's desired outcomes	59%
Fall risk screening	55%
Distribution of Endorsed Intervention Care Processes	
Use of assistive devices and equipment	75%
ADL retraining	63%
Proper body mechanics to reduce injuries	59%
Muscle strengthening exercises	50%
Distribution of Endorsed Discharge Planning Care Processes	
Engage the patient and caregiver in discharge planning	57%
Information on purchasing assistive devices and equipment	55%
Conduct home and environment assessments and modifications	54%

Table 2 Note: Care processes receiving less than 50% endorsement from participants, included:

Assessment domain—balance assessment (41%), home and environment assessments and modification (35%), screening of patients for cognitive impairment (30%), standard time within admission to conduct assessment (28%), conduct appropriate psychological assessments/interventions or be aware of signs and symptoms of depression & other disorders (13%), identify caregiver's desired outcomes for the patient (12%), screen patients for health literacy (1%)

Intervention domain—early mobilization within 24 hours of surgery (42%), home/environment assessments and modification, training (34%), account for the home environment in designing intervention (25%), environment modifications to accommodate patient needs, preferences and physical limitations (19%), coping strategies for loss of physical capabilities (17%), giving patients opportunities to perform activities outside of rehab context (17%), engage patient in conversations of topics of interest (17%), coping strategies for fear of falling (16%), falls management after discharge (15%), coping strategies for fear of subsequent event (11%), electrical stimulation aimed at alleviating pain (9%), engage in problem solving (8%), two-week weight bearing program (4%), nutritional/diet management and nutritional issues pertaining to condition (4%), incontinence management (3%), conduct appropriate psychological assessments/interventions or be aware of signs and symptoms of depression and other disorders (2%), stress management techniques (1%)

Discharge planning domain—prepare patient and caregiver for “Red Flag” warnings (36%), educate on subsequent/follow-up services and recommended referrals (30%), ensure that patient/caregiver understands the importance of provided information (30%), education about care transition (25%), explain rationale of treatment and discharge criteria to caregiver/ patient (25%), identify and follow through on discharge plan in a timely way; provide closure on the day of discharge (24%), two-way informational sharing, promoting mutually beneficial relationships between health care providers and family caregivers (19%), accessibility to health care professional after discharge to answer questions (18%), engage patient in care transition planning (15%), additional educational resources post-discharge, including outpatient educational classes and a contact person from the discharging facility who patient could call (15%), coordination of multiple services geared toward structured education of aftercare needs (14%), medication management & side effects (9%), provide convenient access to searchable resources and information (8%), identify government- and community-based programs and organizations (8%), structured feedback following the discharge (8%), management of insurance coverage and hospital bills (0%)

Table 3
Distribution of Endorsed Caregiver Training and Patient Education Care Processes

	Caregiver Training (%)	Patient Education (%)
Fall Prevention	60%	62%
Use of assistive devices and equipment	55%	65%
Training the caregiver about patient-related home care knowledge	54%	65%
Training the caregiver and patient on the balance between patient autonomy, abilities, and inabilities	51%	62%

Table 3 Note: Care processes receiving less than 50% endorsement from participants, included:

Caregiver training domain—preparation of the patient and caregiver for “Red Flag” warnings (26%), family readiness in preparation for their supportive and caregiver roles (24%), falls management after discharge (20%), provided constructive feedback to caregiver providing care (20%), functional limitation (post-acute illness) impact on occupation, routine, lifestyle (20%), facilitating caregiver skills for their caregiving role at home (17%), risk factors for subsequent acute event/lifestyle and behavioral changes to prevent subsequent acute event (14%), empower patients & caregiver to be informed about disease process & recovery(14%), expectation of caregiver role at home (8%), education about care transition (8%), utilizing the caregiver as motivator (7%), educate on subsequent services follow-up services and recommended referrals (7%), medication management and side effects (7%), explain rationale of treatment and discharge criteria to caregiver and patient (7%), teaching caregivers and patient how to manage psychological, emotional and behavioral problems/identify signs and symptoms (6%), facilitate communication between caregiver and patients and professionals (6%), recognize and build on the expertise of the caregivers (5%), stress management techniques (4%), convenient access to searchable resources and information (4%), training caregivers emotional coping strategies in providing care to patient (3%), revise management plans to optimize caregiver's abilities and resources (3%), inform patient and caregiver how the condition may impact the patient and caregiver psychologically and socially (2%), nutritional/diet management and nutritional issues pertaining to condition (2%), management of insurance coverage and hospital bills (0%)

Patient education domain—prior to procedure/admission, patient received information regarding aftercare needs & services (37%); falls management after discharge (32%); risk factors for subsequent acute event/lifestyle and behavioral changes to prevent subsequent acute event (32%); expectation of caregiver role at home (25%); explain rationale of treatment and discharge criteria to caregiver/patient (19%); educating patient on progress results of measures/outcomes for care plan decisions/revisions (18%); training caregivers/patient on disease (condition) process, causes & symptoms (16%); management of insurance coverage, hospital bills (16%); ensure that patient/caregiver understands the importance of the information provided (14%); coaching patient to accept help from others (12%); medication management and side effects (12%); convenient access to searchable resources and information (10%); education about care transition (8%); inform patient and caregiver how the condition may impact the patient and caregiver psychologically and socially (7%); stress management techniques (6%); teaching caregivers and patient how to manage psychological, emotional and behavioral problems/ identify signs and symptoms (6%); patients and caregivers having the necessary information and knowledge (6%); functional limitation (post-acute illness) impact on occupation, routine, lifestyle (4%); facilitating communication between patients and providers (4%); preparation of the patient and caregiver for what to expect, including symptoms to monitor “Red Flag” warnings (3%); empower patients and caregiver to be informed about disease process and recovery (2%); patients and providers make decisions together while accounting for scientific evidence and patient's values (e.g., shared decision making) (2%); nutritional/diet management and nutritional issues pertaining to condition (0%)