DISCHARGE PLANNING
ADVISOR

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IN THIS ISSUE

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Iowa COC project seeks to prove importance of discharge planning

Goal is to show safety, health benefits

Discharge planners know intuitively that what they do matters to patients' health and safety and to reducing the public health costs of repeated hospitalizations.

The problem is convincing hospital executives of these benefits when there is inadequate literature to offer as evidence.

Researchers involved in a new study hope to find evidence of better outcomes when a thorough discharge planning intervention is used. This huge study, which now is underway, could provide the answers that discharge planners and other health care professionals seek.

The Iowa Continuity of Care study will investigate outcomes among 1,000 patients post-discharge to compare the typical discharge process with both a minimal intervention and an enhanced intervention.[1]

"Often the hospital discharge is a quick and chaotic event," says **Barry Carter**, PharmD, FCCP, FAHA, a professor in the division of clinical and administrative pharmacy in the college of pharmacy at Carver College of Medicine in Iowa City, IA. Carter also is a professor and associate head for research in the department of family medicine at Carver College and a senior scientist with the Veterans Affairs Iowa City Health Care System in Iowa City.

Patients are worried about how they'll return home and may find it difficult to concentrate during the discharge planning meeting, he notes.

Carter and co-investigators are testing an intervention that provides enhanced discharge planning throughout a patient's hospital stay.

"So, the medication education is not provided in that alarming way it sometimes is during the last few minutes as a patient walks out the door," Carter says.

A pharmacy case manager meets with patients daily during shorter stays and less frequently during long hospitalizations.

"The pharmacy case manager tries to meet with patients daily and walks through the medications they'll be taking when they return home," Carter explains. "Then the pharmacy case manager calls the patient three-to-five days after discharge and asks the patient if there are any questions or problems and if they were able to fill all medications at discharge."

If there are issues to address, the pharmacy case manager works with

the patient until these are resolved, Carter adds.

Also, the case manager sends detailed reports to each discharged patient's community physician and community pharmacist.

This enhanced intervention will be compared with two other study arms for adverse drug events, re-hospitalizations, and unexpected visits to the emergency room, Carter says.

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The intervention also will address health care costs.

"The study could show that if we looked at this strictly from the hospital's perspective, it is a money-losing proposition, because they've expanded all of these resources in getting information out to the community providers," says **John Brooks**, PhD, an associate professor in the program in pharmaceutical economics in the college of pharmacy at the University of Iowa.

"It might turn out that the benefits to society are accruing outside the hospital," Brooks says. "We'll look at both society's perspective and the hospital's perspective."

If the study shows substantial cost savings to payers because of the intervention, then its findings could be used to have a discussion with payers and policymakers about reimbursing hospitals for this service, Brooks explains.

An insurer could say it's willing to reimburse for the service, and it would save money even if it paid the hospital more up-front, Brooks says.

"If the study shows there are a lot of benefits to patients and payers, meaning Medicare, Medicaid, or Blue Cross/Blue Shield, then a wise payer would turn to the hospital and say, 'We need you to provide extra services to us before patients check out,'" Brooks says.

Funded by a $3.6 million grant from the National Heart Lung and Blood Institute (NHLBI), this is the largest study of its kind, he notes.

"Our study is not only larger, but it's more encompassing in collecting adverse event data," Carter says.

The hospital in which the study will take place currently provides discharge planning through having a nurse on the patient's floor give the patient a list of medications before the patient is sent home, Carter says.

If the Iowa study shows positive outcomes for the enhanced discharge planning arm, then it's possible it will influence a change in how that hospital and others do discharge planning, Carter says.

"I would hope the hospital would switch to using the intervention," he says. "If it works, then it will encourage hospitals to do the same, and we could make presentations to The Joint Commission and other organizations."

Improving communication is a central theme of the project, says **Alan J. Christensen**, PhD, a professor in the departments of psychology and internal medicine at the Carver College of

SOURCES

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Medicine. Christensen also is a senior scientist with the VA Iowa City Health Care System.

"Our central issue is recognizing that someone drops the ball at discharge," Christensen says.

"Either information is not conveyed in a manner adequate to the patient's understanding, or the patient doesn't hear it because of some barrier in communication," Christensen adds. "Or, the patient hears it, but when he goes home there's some other barrier, such as financial, structural, or cognitive that prevents him from following through."

These barriers, whether psychological, behavioral, social, or financial, can be overcome if discharge planners recognize them and educate patients about coping strategies. **(See story on handling barriers to adherence, p. 64.)**

Pharmacy case manager **Cindy Webber**, PharmD, who has been meeting with patients enrolled in the study, says the interventions take time.

Webber provides discharge planning for patients enrolled in either the minimal intervention or enhanced intervention arms. But for patients in the enhanced intervention arm, she also writes a detailed discharge care plan that is faxed to community physicians and pharmacists, she says.

"When they're going home after I've done the discharge teaching with them, the study manager tells me whether they're in the minimal group or the enhanced intervention group," Webber explains. "Then I make a discharge care plan, which goes out to the enhanced only."

The discharge care plans inform physicians and community pharmacists about the patient's medical status and discuss any problems that need to be monitored, says **Karen Farris**, PhD, RPh, a professor of pharmaceutical socio-economics at the University of Iowa. Farris is a co-investigator with the study.

Pharmacy case managers lay the groundwork for patients' discharge education through the daily meetings and medication teaching, Farris says.

"At discharge we talk about new medications, how to take them, and why they're important," Farris says. "We try to identify any situation where we have a patient on a loading dose and maybe have to change it, or if they need to get in the lab in a certain time-frame or have a particular symptom to address."

For the enhanced intervention arm of the study, the pharmacy case manager will make the post-discharge phone calls to see if patients are having any new symptoms or problems with their medications, Farris adds.

"And if there's an issue ,then the care providers, depending on the situation, will contact whoever needs to be contacted to manage that situation," she says.

For example, if a patient returns home with a diagnosis of heart failure, and while home the patient's breathing worsens, the pharmacist case manager will find out this symptom change when she contacts the patient in a follow-up call, Farris explains.

"If it looks like the drug isn't helping, then the patient might need to see his doctor, and the pharmacy case manager would talk to the primary care physician," Farris says. "Or if the patient has a complication arising from the discharge, then the case manager would talk with the inpatient physician to discuss what's going on."

Reference

1. Carter BL; Farris KB; Abramowitz PW, et al. The Iowa Continuity of Care study: background and methods. *Am J Health-Sys Pharm*. 2008;65(17):1631-1642. ■

DPs can address patients' adherence barriers

Understanding and behavioral are big ones

One key to discharge planning is understanding what might prevent your patient from following medication and other instructions.

Once you have an idea of what the patient's adherence barriers are, you can find solutions.

A substantial reason why continuity of care fails is that once patients are discharged, they're on their own with taking the medications they're given and following their discharge instructions, says **Alan J. Christensen**, PhD, a professor in the departments of psychology and internal medicine at the Carver College of Medicine of Iowa City, IA. Christensen also is a senior scientist with the Veterans Administration Iowa City Health Care System.

Christensen describes the following potential barriers to discharge adherence:

• **Psychological:** "Does the patient understand the instructions?" Christensen says.

Patients' mental status and cognitive capacity should be assessed to make certain the patients are capable of following a complicated set of medication instructions, Christensen says. **(See story on assessing health literacy, p. 69.)**

"There are related issues like the division of attention during this stressful time period," Christensen notes. "I've never been in a hospital as a patient, but I know things are happening fast and furious, and a patient's attention is divided."

Patients already have extra cognitive demands, so it makes it difficult for them to concentrate when a discharge planner asks them to think about medication instructions, he adds.

"It's not only the demented patients who have trouble," Christensen says. "Most of us would have less than perfect memory, processing, and attention in that situation."

• **Behavioral barriers:** Cognitive barriers relate to understanding the instructions, and behavioral barriers relate to acting on what's taught, Christensen says.

Just because a patient understands what the discharge planner says doesn't mean the patient will follow instructions, he adds.

The reason why is that it's difficult to remember to take one's medications at certain times of the day, Christensen explains.

"This overlaps with the cognitive, but we address it separately," he says. "We address the cognitive barriers by simplifying the instructions, and we address the behavioral barriers by giving people pill boxes and memory aides to use."

Discharge planners can provide patients with behavioral cues that will remind them of how and when to take their medications.

For instance, a discharge planner can show a patient how the medication is taken by having the patient demonstrate taking the pills, Christensen suggests.

"And we often talk about linking medication administration with other daily tasks that are habitual, such as brushing your teeth," he adds. "So you tell a patient to take his medication when he brushes his teeth in the morning and when he eats dinner at night, instead of saying he should take the pills in the morning and at night."

• **Social barriers:** For some patients, such as HIV-infected patients and diabetics, there might be a social stigma attached with taking medication or giving themselves injections, Christensen says.

"For younger, active patients there is a stigma associated with medication-taking, particularly if it involves having to give yourself an injection before a meal if you're a diabetic," he says.

There also are patients who don't like to take their medications during certain social situations or when other people are around, Christensen adds.

Another social barrier includes transportation problems, such as not having a way to go to the pharmacy and pick up the prescriptions, he says.

For these patients, the solution might be to have them use a mail-order pharmacy.

"But if they can't use a computer and are not that good on the telephone, then it might be an issue," Christensen says.

So part of the discharge planner's job is educating them about what options there are in terms of ordering prescriptions by mail and how to refill their prescriptions over the telephone or computer, he adds.

*** Financial barriers:** For some patients, the solution to financial barriers is to change their medication to generic forms, he says.

Other patients might need additional help, such as assistance from a hospital program that provides an initial supply of medications, Christensen says.

"But that depends more on the patient's long-term chronic regimen," he adds. "Because sending

someone home with a seven-day sample of pills to get them started is not related to adherence over the long run." ■

Pre-admission prediction tool improves process

Idea is to gain patient buy-in

Sometimes the best response to regulatory and payer changes in health care is to improve the discharge planning process.

And sometimes the best way to improve the discharge planning process is to start discharge planning before the patient is admitted to the health care facility.

This essentially is what happened when a team of leaders looked at the industry changes occurring in orthopedic surgery discharges and post-surgery rehabilitation and realized that something major would need to be done.

A clinical performance management team at Massachusetts General Hospital in Boston, closely examined orthopedic surgery costs, length of stay (LOS), process improvement, and Medicare regulatory changes, says **Pamela J. Tobichuk**, RN, ONC, a nurse case manager with the pre-admission orthopaedic total joint program at Massachusetts General Hospital in Boston. Tobichuk spoke about using a pre-admission prediction tool to improve the discharge process at the 18th annual conference of the Case Management Society of America (CMSA), held June 17-20, 2008, in Orlando, FL.

"Most of our population wouldn't be able to go to an inpatient rehabilitation facility," Tobichuk says. "The majority would need to go home or to skilled nursing facilities, which was a huge difference in what they were used to."

The regulatory and payer changes meant too many issues would need to be resolved: First, patients might have expectations that could not be met, and secondly, the hospital's LOS for these patients might increase as a result of fewer viable discharge options. **(See story on how patients' perceptions guide discharge education, p. 67.)**

"We wanted to be proactive and see how we could maintain our good LOS, if not decrease it, and yet manage patients' expectations around what they'd be doing after surgery," Tobichuk says.

One member of the clinical performance management team came across a risk assessment tool that looked useful. It was described in a 2003 issue of the *Journal of Arthroplasty*, in an article, titled, "Predicting risk of extended inpatient rehabilitation after hip or knee arthroplasty."[1]

"We took this tool back to the team and said, 'How can we use this as a starting point for our program?'" Tobichuk says. "And that's where the development and implementation began."

After receiving permission to use the tool, the team adapted it for their own use, primarily by changing words to work better for an American population. The tool had been used in Australia, she notes.

The resulting six questions are scored with two-or-three point answers, meaning the patient is at the lowest risk, and one-or-zero point answers, meaning the patient is at the highest risk, Tobichuk says.

Tobichuk calls patients prior to their surgery to ask them the tool's questions. As the patient gives answers, Tobichuk assesses their risk and discusses their post-discharge options, asking them, "Do you have a plan or preference for your discharge?" **(See how the pre-admission discharge planning process works, p. 66.)**

Here are the tool's questions:

- What is your age?
- What is your gender?
- How far on average can you walk?
- What do you currently use to help you walk?
- Do you currently have any help from the community?
- Will someone be living with you who can care for you after your operation?

There is a maximum of 12 points. Anyone who scores greater than nine points is at the lowest risk for needing to be transitioned to a skilled nursing facility, Tobichuk says.

"If someone scores 10-12 points, then let's have that person go home," she adds.

At the other end of the spectrum, if a patient's score is less than six points, then that patient is at a high risk, she says.

"We would predict that patient would have to go to a skilled nursing facility for nursing rehabilitation," Tobichuk says.

Patients whose scores fall in the middle category of six to nine have moderate risk, and their discharge outcome is unpredictable, she adds.

"They either could go home with a visiting nurse or be transferred to a skilled nursing facility," Tobichuk explains. "If someone scores in the

SOURCE

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middle range and their preference is to go home, then that might be someone who could benefit from more physical therapy in the hospital to help them get over the hump, and we might send them home with more support."

When using the tool to assist with discharge planning, it's important to consider the patient's general motivation to work at rehabilitation in whichever setting the patient might prefer.

A patient who scores at low risk and who is highly motivated might not need home care services, but could go directly to outpatient physical therapy after being discharged from the hospital, Tobichuk says. ■

DP process begins five weeks before surgery

And ends after discharge

Discharge planning for orthopedic surgery patients at one major hospital begins well in advance of patients being admitted for surgery.

In fact, the discharge planning process begins about five weeks before the surgery, when the case management department sends patients a letter asking them to call a case manager for a 20-minute telephone interview, says **Pamela J. Tobichuk**, RN, ONC, a nurse case manager with the pre-admission orthopaedic total joint program at Massachusetts General Hospital in Boston.

"We have a list of upcoming surgeries through the scheduling operations," Tobichuk says.

Tobichuk has found that it works better to ask patients to call them to schedule the initial telephone interview, rather than having case managers call them at home and catch them off guard or at a bad time, Tobichuk notes.

"I've tried calling patients to do the interview, and it didn't work," she adds.

With administrative support to pick up the voice mail messages from patients, Tobichuk has found the scheduled interviews to be an efficient use of her time.

"My hours are from 10 a.m. to 8:30 p.m., three nights a week," she says. "My hours are such that I can accommodate people, and I'm also talking to facilities and agencies throughout the day."

By scheduling the calls, patients and their families also benefit.

"I've found that patients will have their families over when I call, and they'll have me do a conference call to include the family in on the conversation," she adds.

This first telephone conversation is used to assess the patient's risk post-surgery and to work with the patient to come up with a plan for where the patient will be transitioned after surgery. They use a six-question, pre-admission prediction tool.

Then Tobichuk will ask about the patient's needs and thoughts and then review the patient's answers to the assessment questions.

"In addition, we're adding questions about their living situation and the layout of their home," she adds. "Then we come up with their score, and we talk about it and what it means in relation to what they want."

The patient will agree to a plan, and if Tobichuk agrees with it, they'll proceed in that direction.

Occasionally, a patient will insist on a plan that Tobichuk believes will not work, so she'll agree to keep that as plan A, but will also develop a plan B as a back-up.

She tells such a patient: "We know you want to go home after surgery, and you scored seven points on the risk tool, so we'll try to get you home, but if your body doesn't cooperate with it, you need a back-up plan," Tobichuk says.

Once these telephone conversations and pre-admission assessments take place, Tobichuk can decide whether a patient needs more education, and she can assess the patient's needs for pharmacy information.

"And I make follow-up calls to the payer or insurance company," Tobichuk says.

Also, if the patient will be discharged to a skilled nursing facility, Tobichuk will call the SNF and ask them to save a bed for the patient.

"No one will guarantee holding it, but this is a nice population with a quick turnaround, and

they'll only be in the hospital for a few days after surgery," Tobichuk says. "So we can almost hold a place for them in a facility." ■

Patient perceptions guide discharge education process

Patients often want more than what's allowed

Transitions in health care are changing more quickly than patients' expectations, which is why it's important to address these expectations head-on, an expert notes.

"That's been one of our greatest challenges — setting appropriate expectations," says **Pamela J. Tobichuk**, RN, ONC, a nurse case manager with the pre-admission orthopaedic total joint program at Massachusetts General Hospital in Boston. Tobichuk spoke about using a pre-admission prediction tool to improve the discharge process at the 18th annual conference of the Case Management Society of America (CMSA), held June 17-20, 2008, in Orlando, FL.

Sometimes patients will have a long lag time between when they are first told they will need elective joint therapy and when they actually schedule such therapy, Tobichuk says.

"They've had all this time before the surgery to build up expectations," Tobichuk says. "They might have a preconceived notion about what it is they'll do, and way back when they first met with the physician this was not part of the conversation or focus."

Another reason expectations might be different is that patients often have a friend, spouse, or neighbor who has been through similar therapy, and the way this other person's discharge was handled was different, she adds.

For example, it's possible the patient's husband had knee surgery a few years ago, and the spouse was discharged to an acute rehabilitation facility.

Now, because of payer and Medicare changes, this option is unavailable to the wife, and yet she expected that's precisely where she would go after discharge.

"Most times we ask the patient, 'What is your plan?' and the patient might answer, 'Oh, I'm going to Spaulding Rehab,' which is an acute rehab facility," Tobichuk says.

So it's the discharge planner/case manager's job to educate the patient about which options are available.

"I educate patients on the levels of care, home care, and even outpatient therapy," Tobichuk says. "We teach patients that they'll have some sort of therapy or rehabilitation, but we better define how this will be done."

For instance, low-risk patients who are highly motivated might be sent home and referred directly to outpatient therapy, she explains.

Mid-level risk patients might be sent home to receive home care, including therapy in the home, and high-risk patients might be discharged to a skilled nursing facility, where they receive physical therapy.

Occasionally, a patient will insist that a referral be made to acute rehabilitation.

In answer the discharge planner can say, "Okay, I'll put the referral in, but I'm telling you this is unlikely," Tobichuk says.

The key is to engage the patient in the conversation, obtaining the patient's ownership of the discharge process.

Patients who feel that their opinions and concerns were heard and who are well-educated on what will happen to them post-discharge often report reduced anxiety about the discharge process.

"I try to explain that everyone's situation is different," Tobichuk says. "We look at every case independently, and we try to give them an opportunity to be proactive in their own discharge plan, to empower them to make some decisions about what they're going to need." ■

LEP patients need solid translation services

Translation at discharge is crucial

Hospitals across the United States are seeing an increase in patients who have limited English proficiency (LEP), and this means discharge planners must plan accordingly.

A researcher who has studied the impact of having an enhanced interpreter service intervention says she conducted her study out of concern about LEP patients receiving substandard care.

"I was shocked as both a medical student and resident that patients who didn't speak English well didn't receive the standard of care," says **Elizabeth Jacobs**, MD, MPP, an associate professor of medicine in the collaborative research unit

at the Stroger Hospital of Cook County and Rush University Medical Center in Chicago.

One of the most important facets of the standard of care is communication, and these LEP patients often lacked having a physician or discharge planner or other health professional who could communicate effectively with them, she notes.

"We need to understand what it is that patients need, what their conditions are like at home, and we need to give them adequate instructions about medications when they leave the hospital," Jacobs explains. "Or they'll return to the hospital."

Language barriers are addressed inconsistently across the continuum of care, Jacobs says.

"The problems that arise come when there are not people employed at the hospital who speak the language of LEP patients, including not having Spanish-speaking discharge planners," Jacobs says. "Interpreters can help overcome those barriers, but frequently those resources are not in place, and patients may not have access to video interpreters or telephone interpreters."

What happens instead is that hospitals rely on untrained bilingual staff or the patients' children, family members, or even the patient in the next bed to serve as ad hoc interpreters, Jacobs says. **(See anecdote about how family interpreters can impede medical care, p. 69.)**

This haphazard approach creates problems, especially since these ad hoc interpreters often would not test as truly bilingual, and they might not understand the medical terminology, she adds.

"So a discharge planner is trying to communicate, but the message is not communicated, or it's miscommunicated, and the discharge planner might never find out that the patient was given incorrect information," Jacobs says.

For instance, a patient who has heart failure might need to be told to take a certain medication, to weigh himself every day and then to call the nurse or doctor if the weight goes up, she says.

"But if the patient doesn't understand the discharge instructions and doesn't take his medication correctly, then he won't be adequately treated and will go back into the hospital," Jacobs adds.

"I'm someone who feels very strongly that we should provide good interpretation or good communication in a language the patient can understand throughout the hospital encounter," Jacobs says.

But there are three crucial points where having a medical interpreter is essential, she notes.

"One is when you make a diagnosis, the second is when you have to obtain informed consent for procedures and are trying to communicate to patients how to make decisions about their care," Jacobs says. "And the third is when they are being discharged and are receiving discharge planning."

If a hospital must prioritize the expense of professional interpreter services, then it should at least have a medical interpreter available at these three junctures, Jacobs says.

"I advocate for having them available at all points of care, but if you must prioritize, then I'd prioritize those three time points," she adds.

Jacobs' research concluded that having an enhanced interpreter service intervention did not significantly impact costs.[1]

Having this interpreter service available did reduce return emergency department visits, however.[1]

The study noted that the cost of having an enhanced interpreter service was $234 per Spanish-speaking intervention patient, and it represented just 1.5 percent of the average hospital cost. But it was even more cost-effective to have a Spanish-speaking attending physician, and this also significantly increased the Spanish-speaking patients' satisfaction with the doctor and hospital.[1]

"My research and other research have shown that if you provide adequate communication to a patient with LEP, then you have an opportunity to save on costs," Jacobs says.

"It's very inexpensive in the scheme of things compared with what we pay for in health care," she adds.

"For instance, in this study, I showed that providing the interpreter intervention represented just 1.5% of total hospital costs, which is incredibly small and represents the amount hospitals pay for an X-ray for hospitalized patients," Jacobs says.

Also, there are many costs that researchers have difficulty capturing, but they're still important for hospitals to think about, including the issues of malpractice, she adds.

"It only takes one million-dollar case to wipe out the cost of providing interpreter services over a three-to-five-year period in a hospital," Jacobs explains. "And there are health costs to the patient with not receiving adequate medical care."

SOURCE

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In Stroger Hospital, there are interpreters who speak Spanish, Polish, Russian, and a couple of Chinese dialects, Jacobs says.

"The staff interpreters mostly are here during the week, but there's always somebody available 24 hours a day for Spanish," she says. "And there's always access to telephone interpretation services 24 hours a day, so we have 24/7 coverage, but it's just not all face-to-face interpreters."

Reference

1. Jacobs EA, Sadowski LS, Rathouz PJ. The impact of an enhanced interpreter service intervention on hospital costs and patient satisfaction. *J Gen Intern Med*. 2007;22[Suppl2]:306-311. ■

Family interpreters can cause harm

They might purposely misinterpret

When hospitals rely on a patient's family members to interpret medical news, they might be placing the patient at risk, an expert says.

Family members sometimes purposely misinterpret information because of their own biases or agenda, says **Elizabeth Jacobs**, MD, MPP, an associate professor of medicine in the collaborative research unit at the Stroger Hospital of Cook County and Rush University Medical Center in Chicago, IL. Jacobs recently studied the impact of having an enhanced interpretation service on Spanish-speaking patients' satisfaction and on hospital costs.

"When I ran the study, one of the things our interpreters did was introduce themselves to each Spanish-speaking patient, saying, 'My name is so and so. Here's my card, and you can keep it at the bedside and show to your doctor and family members,'" Jacobs says.

In one case, a family member told the interpreter, "No thank-you, we won't need your services," Jacobs recalls.

The interpreter told the family that the service was free, but the family still declined.

With a little investigation, the interpreter found that the family did not want the patient to know about her diagnosis, so the interpreter called Jacobs with this information.

"I told her I was glad she called me, and I called the attending and said, 'I want to make you aware of this situation,'" Jacobs says.

Jacobs advised the attending physician to be culturally sensitive, but to give the patient the option of refusing the interpreter services and relying on family members.

"I told him, 'You can get an interpreter to go in there and ask what the patient would like, saying the family would like to be the ones to give you all of the information, or we could have an interpreter in here to talk with you directly about your health,'" Jacobs recalls.

The doctor handled the case as Jacobs' recommended, and the patient chose to have a medical interpreter present, Jacobs says.

"In 80% to 90% of cases the patient does want the information from an interpreter," she adds. "And that's an example of what happens if you use an ad hoc interpreter."

Family members often will change the conversation or distort the doctor's words, often out of love and a misguided feeling that it's in the patient's best interest, Jacobs explains.

"So the doctor could be treating a patient with chemotherapy and not know that the patient doesn't even know her diagnosis," Jacobs adds. ■

Assess patients' health literacy before teaching

New assessment tools work well

Too often health care professionals give patients instructions and education without taking the additional step of making sure they understand.

"We talk about what they need to do — that's how we're all trained," says **Susan A. Rogers**, RN-BC, BSN, CCM, president of Rogers Professional Guidance in Overland Park, KS.

Rogers spoke about assessing health literacy at the 18th annual conference of the Case Management Society of America (CMSA), held June 17-20, 2008, in Orlando, FL.

"We never take time to ask if individuals are hearing and understanding what we say to them," Rogers says.

"As we become more of a consumer-defined world, health care has made the change toward the consumer as the focal point," she adds. "When we were trained back in the day it was all about the doctor."

As part of this new patient-centered process, discharge planners and case managers need to assess each patient's health literacy in order to adapt the educational message.

"The whole premise is that you assess the patient with assessment tools that give you an understanding of where the patient is with their knowledge, as well as the patient's motivation with regard to medication adherence," Rogers explains.

One available tool is the Rapid Estimate of Adult Literacy Measure (REALM), which is a one-page sheet listing health words like "constipation," she says.

Discharge planners then ask patients to read the list, and this helps to identify people who have low reading skills and who might be able to read some words but are unsure of their meaning.[1]

Another test that could be given is the Test of Functional Health Literacy in Adults (TOFHLA), which measures reading comprehension and numeracy, using health-related materials like a typical appointment slip.[2]

According to Peppercorn Books, which publishes the TOFHLA (www.peppercornbooks.com), the tool includes multiple choice questions such as the following:

* Your doctor has sent you to have a _____ X-ray.

a. stomach
b. diabetes
c. stitches
d. germs

The shortened version of the TOFHLA takes only seven minutes to complete, Rogers notes.

"The longer one is 50 items and takes about 22 minutes, but the seven-minute version will get you the information you need," she explains.

The theory behind assessing health literacy is that it's difficult for people to take care of their own health care if they don't understand what their health care providers are saying, Rogers

CNE *questions*

9. Which of the following is a type of medication adherence barrier experienced by patients newly discharged from a hospital?
A. Financial
B. Psychological
C. Behavioral
D. All of the above

10. Which of the following is <u>not</u> a question included in a pre-admission discharge planning tool that has proved effective at the orthopedic program at Massachusetts General Hospital?
A. What is your age?
B. Will someone be living with you who can care for you after your operation?
C. Do you bathe or shower?
D. How far on average can you walk?

11. A study of outcomes when a hospital used interpretation services to meet the needs of limited-English proficiency (LEP) patients found that such services represented which percentage of total hospital costs?
A. 1.5 percent
B. 3.7 percent
C. 6.6 percent
D. 14.2 percent

12. True or False: It's always better to use the patient's family members for interpreting medical information when the patient has limited English proficiency.
A. True
B. False

Answers: 9. D; 10. C; 11. A. 12. B

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with this, the November/December issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

says.

A third tool is the Newest Vital Sign, an English and Spanish health literacy screening tool developed by Pfizer and available through the web site: www.pfizerhealthliteracy.com.

The tool shows patients a sample food nutrition label and then asks them to answer questions about the label, including this question: "If you usually eat 2,500 calories in a day, what percentage of your daily value of calories will you be eating if you eat one serving?"[3]

"I really like the Newest Vital Sign," Rogers says. "If they can't comprehend this kind of label, which they see every day, then it's a pretty good assessment that their health literacy is not where it needs to be to comprehend the more complex instructions, like preparing for an MRI."

Rogers has used the Newest Vital Sign with patients and has found it to be a good indication of whether a diabetic patient, for example, will understand his own nutritional and exercise needs and insulin dose changes with exercise and eating, she says.

"This gives you a good clue of what a patient will do in the real world," Rogers adds.

Assessing health literacy also requires paying close attention to a patient's learning style and motivation to follow medical instructions.

Rogers visualizes this as a table with knowledge and motivation as two categories and the assessment divided between low and high.

A person might score as being highly motivated, but has low knowledge. In this case, the discharge planner should simplify instructions and spend a little more time with the person.

Or someone might demonstrate the opposite of high knowledge and low motivation, and it would be the discharge planner's job to find out what the obstacles are to the patient's willingness to carry out instructions.

Another way to conceptualize health literacy is to categorize how people learn, Rogers suggests.

While there's some overlap, most people could be said to favor one of these three ways people learn: through seeing, through listening, and through experiencing.

"The listeners are the people who've heard mom say a million times to not touch the stove when it's turned on, and they believe the information and never touch the stove," Rogers explains.

"The people who learn through seeing are the ones who heard mom's message, but didn't quite believe it until they saw their brother touch the stove," Rogers adds. "And the experiencers are those who say they won't believe it until they try it and touch the stove for themselves."

It's helpful to know which of these three types of learners a patient is before a discharge planner provides written or video or other types of information.

For instance, the stakes might be higher with patients who learn through experiences.

Rogers recalls that her own grandmother was someone who would learn through experience.

"She was a diabetic, and when she came out of the doctor's office one time I asked her if she told the doctor about the sore on her foot," Rogers says. "She said, 'No, he's the doctor, and he

CNE objectives

To earn continuing education (CNE) credit for subscribing to *Discharge Planning Advisor*, CNE participants should be able to:

- Identify particular clinical issues affecting discharge planning.
- Apply discharge planning regulations to the process of discharge planning.
- Describe how the discharge planning process affects patients and all providers along the continuum of care.
- Cite practical solutions associated with the discharge planning process based on independent recommendations from clinicians working in the field or from specific regulatory bodies. ■

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SOURCE

For more information, contact:

- **Susan A. Rogers**, RN-BC, BSN, CCM, president, Rogers Professional Guidance, Overland Park, KS. Email: susan@4casemanagement.com.

knows what to ask and if he didn't ask me about my foot then it's not important.'"

Unfortunately, it was important because her grandmother later ended up having an amputation, and she died from gangrene, Rogers says.

The person who learns through experience often has the attitude of "You can tell me to watch for these symptoms, but if you're not going to pay attention to it, then I'm just going to do what I want, and we'll see what happens," she says.

"There are 90 million individuals who cost the health care system $58 billion annually," Rogers says. "So it's not a small problem that people are not adhering to treatment plans and medications."

The key is for discharge planners to spend more time with patients who might fit this bill and make certain they really understand how important it is to watch for symptoms and to adhere to their medication regimens, she adds.

"We have to sit down with these people and see if they're really getting what we're telling them," Rogers says.

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Medicare clarifies privacy of health info

When transferring private health information to potential post-acute providers, discharge planners need to be aware of some facts about the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

According to *MLN Matters*, published by the U.S. Department of Health and Human Services (HHS), provides a clarification about HIPAA's medical privacy rule, including the following:

- Discharge planners do not need to obtain signed consent forms from patients before sharing their medical information for treatment purposes.
- HHS adopted specific modifications to the rule in August 2002, which clarify that incidental disclosures do not violate the Privacy Rule when providers have common sense policies which reasonably safeguard and appropriately limit how protected health information is used and disclosed.
*•Doctors and other providers, including discharge planners, can share needed information with patients' families, friends, or anyone else identified by patients as involved in their care as long as the patient agrees. ■

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