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ADVISOR

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Discharge planners and home care staff need to improve communication

Problems may arise during transition

The transition from hospital to home health can be a rocky one, which is why hospital discharge planners need to make communication with home health staff a priority, experts say.

"Sometimes it doesn't seem as if anyone has been allowed the time needed to prepare for discharge," notes **Lin J. Drury**, PhD, RN, an associate professor in the Lienhard School of Nursing at Pace University in New York. Drury recently published a paper on what gets lost between the discharge plan and the real world when hospital patients are transferred to home care.[1]

"It seems the amount of time for preparing for discharges is decreasing," Drury says.

This has become a more urgent problem as increasing numbers of hospital patients need home health care after their discharge, according to data from the Agency for Healthcare Research and Quality (AHRQ).

AHRQ released a summary in October, 2008, showing how the rate of patients discharged from hospitals who still needed home health care increased 53% between 1997 and 2006. The same summary, which can be found at the web site, www.hcup-us.ahrq.gov/reports/factsandfigures/HAR_2006.pdf, noted a 30% increase in the rate of patients discharged to nursing homes or rehabilitation facilities during the same period.

Another new study shows that physicians are not referring high-risk patients to home care and other post-acute services as frequently as is needed.[2]

"I did an analysis of these patients to look at their medical characteristics and found that these people were pretty darn sick and had lots of needs, and yet they did not get post-acute referrals," says **Kathryn Bowles**, PhD, RN, FAAN, an associate professor at NewCourtland Center for Health and Transitions in Philadelphia.

In all, 56% of patients who had medical needs that experts agreed indicated a post-acute care referral did not receive one, Bowles adds. **(See story about post-acute care referral study, p. 6.)**

From a home care professional's perspective, inefficient communication between the hospital and home care agency can be a problem, says **Mary Kim**, LMSW, a clinical liaison at Attentive-Primecare Home Health in

Plano, TX.

"I used to be a social worker in the hospital and have knowledge of both sides," Kim says. "It's a disadvantage to patients and family if the home care agency does not lay their eyes on patients while they're still in the hospital."

Often, the communication between the two consists of the home care agency asking the hospital to fax over some information about the patient, Kim notes.

"But what you see on paper is not the same as actually seeing the patient," Kim says. "And that obviously can be a big barrier to the patient care."

Attentive-Primecare Home Health encourages hospitals to let Kim and other staff meet the patient to speak with him or her and evaluate the patient's needs, Kim says.

"We try to get an idea of what their expectations are and to see if there are any issues that need to be dealt with prior to the patient being discharged home," Kim says. "The only way we can do this is to literally lay our eyes on them and talk to them."

It's becoming increasingly rare for hospitals and home care agencies to communicate well during a patient's transition in care, Drury says.

"It seems that the number of clients each discharge planner has to handle is so much greater now that they don't have much time do anything more than say, 'Do you have a space for this guy or not?'" Drury explains.

Institutions need to recognize the importance of the discharge planner's role and give them enough time to do what they need to do to take care of people when they're discharged, because the alternative is to have patients who return to the hospital in a medical crisis, she says. **(See story on preventing medical crises in transitions, p. 3.)**

"Institutions are going to need to invest in allowing somebody to really do the discharge planning that's required," Drury says.

Since the typical hospital patient now is older and more frail than a decade ago, patients also are exceedingly ill at the point of discharge, Drury says.

"And the family is completely overwhelmed," she adds. "So unless the discharge planner has time to work with the family, all of the things listed on the discharge planning sheet do not have a chance of being followed."

For instance, during the stressful period of a patient being discharged from the hospital, it's often true that no one thinks about how the patient will obtain his or her medications, Drury says.

"They'll arrive home and realize they don't have any of their medicines," she explains. "Or they'll think they had a bottle of pills at home, but they're not what they thought they were, or they have the wrong dose."

Once upon a time, there might even have been

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a person connected with a health care system who would visit the client's home before discharge to see what it is like, but that role disappeared over 10 years ago, Drury says.

Instead, problems related to a patient's home environment are dealt with when they crop up as an emergency situation. For example, Drury knew a case where a patient was brought home on a stretcher and carried up three flights of stairs to his bedroom, but no one had considered that the house's only bathroom was on the second floor.

From the home care agency's perspective, staff often arrive at a new client's home only to find that the patient doesn't have the proper medication and equipment, Drury says.

"Or even if they have the right things in place, they don't know what to do with them," Drury says. "They thought they understood things before they left the hospital, but they're not able to implement the instructions."

Also, patients and their caregivers often assume that someone else is going to help them with immediate care, and no one is waiting for them when they arrive home, she adds.

"The home health aide won't be with them for a majority of the time they're home recovering, and for the rest of those hours, the family is completely stumped," Drury says. "Home care services are time-limited, and you must be demonstrating definite progress in order to continue to obtain that care."

This is a Catch-22, because the kinds of patients who typically receive home care services are chronically ill, and they often will get worse when they return home, she says.

"And there's not a lot of reimbursement that will allow for continuing care to somebody who is not going to get better," Drury explains. "Your typical Medicare reimbursement for home care after a hospital stay is very, very limited and very time-sensitive, so people often do not receive the full extent of services they would need to get better."

Not only do discharge planners need to work harder to anticipate problems and prevent them during the transition to home, they need to find home care agencies that are willing to go the extra mile.

Kim recently worked with an elderly woman and her caregiver daughter who were very anxious about being transitioned to home care because of the patient's history of having falls in the home.

"The daughter had been making many excuses to delay the discharge, so the hospital's social worker told me that this was a very difficult family," Kim recalls. "The social worker said they needed a home care agency that would connect with the patient and caregiver and take care of them."

Kim spoke with the daughter who had valid concerns about her mother's safety at home.

"We said we'd go to the home and do a safety evaluation, even though Medicare doesn't pay for those now," Kim says. "We had a physical therapist evaluate the patient at home, and we showed the family that they were going to be okay."

The home care staff outlined the steps the family had to take to ensure the patient's safety and agreed on a plan that made each person involved accountable, she adds.

"We would not have known the extent of the family's anxiety if the social worker hadn't given me a heads up about the patient's fears," Kim notes. "This is the collaboration that is needed between the hospital and the home care agency so that we can better serve patients and their families."

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How to prevent crises during transitions in care

Woman lost leg in one tragic case

Discharge planners can prevent many problems that might occur during a patient's transition from the hospital to home care by

focusing on communication with staff from the home care agency or other post-acute setting.

Experts suggest following these strategies:

• **Think about what communication needs to happen:** Discharge planners should think about discussions they'll need to have with home health staff and, in the case of patients who are doing very poorly, discussions with payers, says **Lin J. Drury**, PhD, RN, an associate professor in the Lienhard School of Nursing at Pace University in New York.

"You may need to get in touch with social service staff right away, or you may need to convince Medicare or the managed care organization that quickly discharging the patient is not in the patient's best interest," Drury suggests.

Hospital discharge planners and home care social workers also need to communicate during and after the patient's discharge from the hospital to make sure the transition is smooth.

"There needs to be a follow-up from the hospital, with someone asking if the home care person made it to the home and if the patient is okay," Drury says.

Once a discharge planner has said good-bye to a patient, there needs to be someone on the other side who is making sure everything is working well at home, she adds.

• **Find out what the patient's home environment is like.** After home health eligibility is determined, the discharge planner should ask the patient about his or her home environment to find out if it's handicapped accessible and whether there is adequate electrical supply for any home health equipment.[1]

• **Educate the patient about payer-imposed limitations on services.** "We need to educate the patient regarding insurance and find out what other resources the patient has," says **Mary Kim**, LMSW, a clinical liaison at Attentive-Primecare Home Health in Plano, TX.

"Medicare guidelines have changed, and there are many limitations to what services can be provided," Kim says. "So you have to have a conversation with the patient to help them understand what the situation will be like at home, the limitations and barriers."

The hospital's social worker or case manager should discuss this first, and then it's time to get the social worker from the home care agency to talk with the patient, as well, Kim adds.

"There might be community resources that will work in conjunction with home care to provide transportation and other things," she explains. "The patient might need to hire a private duty sitter for the transition and have all of that in place before going home."

These sorts of decisions could be discussed by the hospital social worker and home care social worker before the patient is discharged, Kim adds.

• **Anticipate and prevent adherence problems.** Discharge planners also need to clarify when and how patients will fill prescriptions and obtain medical supplies after discharge.[1]

And all discharge instructions need to be explained and demonstrated whenever possible.[1]

Teaching patients about discharge plans should be done thoroughly by the hospital discharge planner and then reinforced by home health staff, Kim says.

"We need to educate and constantly reinforce that to not only the patient, but also to the caretaker, spouse, and mother," Kim says. "Hospital social workers and case managers are very good at doing that, but the reality is there's absolutely no way a person will 100% understand the transition until it happens."

So it's important for the hospital to have the home care agency's social worker talk with the patient to provide information about community resources that could work in conjunction with the home care services, Kim suggests.

For instance, the person might need transportation to doctor visits or might benefit from having a private duty aide help with the transition home, she says.

"Also, if a patient is very anxious about returning home, then some home care agencies can do a same-day [as discharge] visit, even though Medicare won't reimburse for that," Kim says. "But we're doing it for the patient's safety."

A home visit also reassures patients that they will be fine once transitioned home, Kim says.

Some patients will become so anxious after being brought home that their health will worsen, and they'll return quickly to the emergency room, she adds.

Sometimes, there are even worse outcomes.

Drury recalls a worst case scenario in which a patient nearly died during a transition gap in care.

"I've done some consulting on medical malpractice cases involving home care agencies," Drury says. "One of the horror stories involved a younger woman who had been in a serious auto accident and was discharged in traction at home."

The woman's only caregiver was her elderly mother, although she had been transferred to a home care agency.

"In the three days between when she arrived home and the home care agency arriving to visit her, the patient developed blood clots because her mother couldn't handle her in traction," Drury explains. "She ended up losing her leg that was in traction."

When the lawsuit was settled, the hospital took responsibility for discharging the patient before the patient and caregiver were ready, and the home health agency took responsibility for not getting to the home fast enough, Drury notes.

"The client got a settlement, but she still didn't have the leg, and her mother continued to feel horrible for the rest of her life," she adds.

Discharge planners need to watch for patients who might need more services and faster services, so these can be discussed with the home health agency to make the transition smoother.

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1. Drury LJ. *J Contin Educ Nurs*. 2008;39(5):198-199. ■

Too few chronic patients referred to post-acute care

Research highlights troubling findings

Clinicians often fail to identify patients who need home care services or other post-acute care after they're discharged from the hospital, research shows.

These chronically-ill patients with comorbidities are the same patients who often end up back in the hospital soon after being discharged, notes **Kathryn Bowles**, PhD, RN, FAAN, an associate professor at NewCourtland Center for Health and Transitions at the University of Pennsylvania School of Nursing in Philadelphia. Bowles has published many studies involving home health and post-acute health issues.

After analyzing data from a clinical trial that enrolled high-risk adults, Bowles made the surprising discovery that more than half of those enrolled were not referred to post-acute services after being hospitalized, despite their high-risk for rehospitalization.

"I started to explore why that happened," Bowles says. "We compared those who received home care and those who didn't and found the two groups looked similar, but some patients were not recognized as needing the service by clinicians making referrals."

After interviewing clinicians about why some patients didn't receive the post-acute referral, Bowles learned that clinicians didn't always know which questions to ask patients and might not be conducting comprehensive assessments. And if the patient didn't request help, they might think it's not necessary.

"A patient might say to the doctor, 'I'll be okay — don't worry about me,'" Bowles says.

Also, there are system obstacles, such as clinicians not having enough time or discharges occurring late on a Friday, she adds.

"There also is a lack of knowledge about home care's value to the patient," Bowles says.

Bowles and co-investigators further studied the issue by reviewing medical records from high-risk patients involved in three clinical trials at six different hospitals in Pennsylvania.

"We generated case studies out of those records so we could compare what happened to them in real life versus what experts said should have happened to them," Bowles explains. "We ended up with 355 case studies that had health characteristics, social, and financial situations, and we sent those to a panel of eight experts."

The panel included both clinicians and academic experts with two physicians, two nurses, two social workers, and two physical therapists.

"They reviewed these cases and told us what they would have done in terms of making a referral," Bowles says.

"Then we ran an analysis of the characteristics of patients associated with the decision to refer to post-acute care, and we compared it with what really happened," she says. "We found the experts referred 56% more patients than what happened in real life."

The study concluded that current hospital discharge referral processes are not adequately identifying at-risk patients.[1] **(See story on improving referrals, p. 6)**

One reason why the experts made more referrals could have been that they were given more comprehensive medical information than what clinicians often see, Bowles notes.

"We put the information all in one place with a case summary, and they could see what patients' needs were, versus the scattered information found throughout a paper medical record," she adds.

Time constraints were a second factor.

"The experts also had time to consider the referral, versus the real life clinical situation of a hectic environment with multiple people making decisions and a lack of clarity over whose role it is to make these decisions," Bowles says.

In earlier research, Bowles and co-investigators found that discharge planners and nurses often cited the pressure to discharge patients quickly as a reason why some at-risk patients might not receive post-acute service referrals.[2]

Weekend discharges were particularly a problem because of short staffing, poor planning, and inadequate communication, the study found.[2]

And the third reason why there was a significant disparity between the experts' decisions and real-life referral decisions was that researchers asked the experts to make their decision based solely on patients' clinical needs and not on insurance and limitations imposed by Medicare, Bowles says.

The experts could look at what these patients' needs were and whether they could benefit from post-acute services without making certain the patient qualified as "homebound" under Medicare rules, she adds.

Of the patients the experts would have sent to home care services but who were not referred in the real-life cases, 23% were rehospitalized within 12 weeks, Bowles says.

"So, they did not get services and went on to have poor outcomes," she says. "They looked a whole lot like the people who do receive home care, so we're missing these people."

As a result of the research, Bowles and co-investigators have developed a prediction model that provides scores related to whether or not patients should be referred to post-acute services. The model is expected to be published soon in *Nursing Research*.

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Improving referrals to post-acute care

Educating clinicians is first step

After years of research regarding post-acute care referrals and outcomes of at-risk patients, a researcher has concluded that more education and discharge planning resources are needed.

"We need to do some work in acute care settings, educating clinicians about what home care can do for patients," says **Kathryn Bowles**, PhD, RN, FAAN, an associate professor at NewCourtland Center for Health and Transitions at the University of Pennsylvania School of Nursing in Philadelphia. Bowles has published numerous studies about discharge planning and post-acute care referrals.

Here are Bowles' tips for improving discharges to post-acute care services:

• Educate clinicians about home health benefits.

"If we give them a better understanding of the value of home care nursing, then clinicians will do a better job of realizing the patient might benefit from home care nursing," Bowles says.

For example, heart failure patients who often return to the hospital with acute flare-ups of symptoms could benefit from having a home health nurse visit them after discharge, Bowles notes.

"The home care nurse could teach them how to watch their weight, evaluate their diet, etc.," she says.

• Take time to communicate all pertinent patient information to the home health nurse.

It also would help improve outcomes when these patients are referred to home health care if discharge planners would let the home health nurse know how frequently the patient has been rehospitalized and of any other priority issues, Bowles adds.

"Hospital communication should be improving, but we still have a gap of getting that information from the hospital to the home care setting," Bowles says.

For instance, in Bowles latest study she assessed the disease management approach of four home care agencies by examining the care provided to patients newly admitted to home care.

"I asked nurses to document patients' hemoglobin A1C, and the home care nurses knew the A1C of their diabetic patients only 13% of the time," Bowles says. "They were not given that information by the hospital."

*** Note national data and trends.**

"There's work going on nationally with the Continuity of Care record, and we should be paying attention to the contents of that," Bowles says. "Discharge planning departments

SOURCE

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should make sure they have access to those data elements within their electronic system, and they can produce summary documents that can be transmitted or faxed to home care agencies."

Likewise, home care agencies need to collaborate with acute care discharge planners to say, "This is the kind of information we want," Bowles notes.

"I don't see that collaboration going on between discharge planners and home care," she adds.

"Discharge planners need to ask themselves whether their system provides this information, and how can we get it to the home care agency," Bowles says.

*** Use electronic records to make time more efficient.**

"Discharge planners are overwhelmed," Bowles says. "People are just getting sicker and sicker, and over the years, their cases have become more intensely complicated."

Discharge planning is an overwhelming job, she adds.

"So we need to use the electronic record to help us and to transfer information," Bowles says.

"My work is about developing decision-support tools for referral decision making, so we can help clinicians identify people, augmenting their decision-making process, who might need a referral," Bowles says.

The tools could send an electronic alert to clinicians, saying, "Have you considered a referral for this patient because their characteristics suggest they might benefit from home care services," Bowles adds.

Electronic records and tools might be a good way of overcoming time constraints in the discharge planning industry, Bowles says. ■

New CM adherence guidelines expected soon

Medication reconciliation is priority

Discharge planners soon will have revised guidelines to assist them with case management adherence.

The Case Management Society of America (CMSA) soon is expected to release a third version of its *Case Management Adherence Guidelines*, says **Susan A. Rogers**, RN-BC, BSN, CCM, president of Rogers Professional Guidance in Overland Park, KS. Rogers has contributed to the guidelines, particularly on the issue of diabetes care.

The second version, published in June 2006, focuses on health literacy, mediation knowledge, motivation, social support, factors that influence adherence, motivational interviewing, and hospital discharge planning and adherence counseling to ensure a successful discharge.[1]

Medication reconciliation is a major part of treatment adherence, Rogers notes.

Discharge planners and others who provide medication reconciliation are crucial to transition of care coordination, Rogers says.

"They assess what medications are at a patient's home, what the patient knows about these medications, when the patient plans to have prescriptions refilled, or when the doctor will prescribe them again," Rogers explains.

Discharge planners and case managers take into account a patient's lifestyle support, health literacy, and adherence motivation, she adds.

"That is a huge thing in today's world," Rogers says. "Up to half of the 1.8 billion prescriptions made each year aren't taken appropriately."

Barriers include lack of transportation, side effects, and forgetfulness.

"These guidelines were developed with all of these in mind," Rogers says. "We case managers and discharge planners have always looked at cost effectiveness and what are the outcomes of our interventions."

Discharge planners educate and coordinate care, but have never really spent a great deal of time promoting adherence and encouraging patients to participate in their own care, Rogers notes.

The adherence guidelines are intended to be used as a resource guide and tool kit.

For example, in the chapter discussing dis-

charge planning, there is a model for a successful discharge plan for successful transition to outpatient care.

The tool lists tasks performed, such as "Patient understands transition plan for care in post discharge setting." And it has columns for assessment, date, reviewer, and notes.

Other tools in the guidelines include patient assessment forms, adherence improvement tools, and a readiness ruler.

"The readiness ruler is an assessment for motivation," Rogers says.

The readiness ruler is a simple drawing of a ruler with a transition of colors from bright red to bright green. Patients are asked to describe how ready they are to make a change. Those who are not at all ready would select the bright red or zero at the far left of the ruler. Those who already are making a change would select bright green or 10 at the far right. Others will fall in between.

It's important for discharge planners to use all of the tools in their arsenals, including health literacy tools, to determine what additional support and education patients might need to ensure treatment adherence. **(See health literacy education)**

CMs need to understand patient literacy

"You need to know if a patient understands what they're taking and whether they have health literacy issues where they may not understand what you're telling them," Rogers says.

Also, discharge planners need to know whether patients have someone at home who can help them, she adds.

"If they don't have help, then you need to use motivational interviewing and psychosocial assessment and questioning to determine whether they want to take their drugs and why adherence might be a challenge," Rogers says.

The CMSA guidelines also provide information about comorbidities, such as clinical depression, that sometimes impact adherence.

For instance, patients who are being treated for depression need to be educated about how their antidepressant medication sometimes takes some time to work and they might not experience an immediate relief from the blues, Rogers says.

"You tell the patient, 'You have to continue to take the medication so that you will feel better,'" Rogers says. "And you have to make sure the patient is safe during the transition of care, noting who will be watching out for the patient after discharge."

Safety is the bottom line for discharge planning.

"We have to keep our patients safe no matter what," Rogers says. "If we release them with a whole bunch of drugs, then we need to make sure they're safe when they get home and they're safe from harming themselves or being a threat to others."

Each disease state has a slightly different assessment, and patients are at various levels of educational knowledge and adherence ability.

Diabetic patients, for example, have a variety of adherence issues, including exercise, food, blood glucose monitoring, and medication, Rogers says.

"We need to know what their motivation is for adhering to their treatment and when it's an appropriate time to provide discharge education," she adds.

Sometimes, patients with complex medical needs, like diabetics, will not be able to handle adherence post-discharge without help. So discharge planners might need to pass the baton to the next person, whether this is a post-acute health care professional, minister, family physician, community pharmacist, caregiver, or someone else, Rogers says.

"It's very important to not discharge the patient and be done with it," she adds. "Part of the discharge planning process is to communicate with the next step and whoever that is."

A full transition to care is very important, Rogers says.

Some patients might need one visit from a home health nurse to reinforce the teaching, she adds.

SOURCE

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Reference:

1. Case management adherence guidelines. Version 2.0. Case Management Society of America. June 2006. Available online at ttp://www.cmsa.org/portals/0/pdf/CMAG2.pdf. ■

Tips to teaching patients with low health literacy

First, assess barriers

The first step to teaching patients who have low health literacy is to assess the barriers to their understanding medical instructions, an expert advises.

"Find out what the problem is — and why they're not getting it," 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.

Barriers could be language or cultural issues, she notes.

"Once you assess the problem, you can handle it," Rogers says.

For example, a discharge planner might use Pfizer's Newest Vital Sign tool to see if the patient can read a simple food nutrition label.

If the patient cannot understand the food label, then it's doubtful that the patient will understand written instructions about how and when to take complicated medication regimens and other health advice.

"So you'll need to keep the message simple," Rogers says. "Don't ask, 'Do you understand?' because the patient probably will say 'Yes,' and nod his head."

People don't like to admit when they don't understand something because it embarrasses them, Rogers says.

Another key to improving communications is to keep written material at the 4th or 5th grade reading level, which is about the same reading level as many popular novels, such as John Grisham thrillers.

"Two out of three people with low literacy hide this from their spouses even," Rogers notes.

Discharge planners also should assess each patient's learning style, Rogers suggests.

Patients who learn through listening to instructions could be given examples of medical instructions verbally and then be asked to repeat these, she says.

"For a seeing learner, you might play a videotape," Rogers says.

Visual learners also might benefit from brochures, if they're medically literate, or being steered toward educational Web sites, if they're technology-savvy, she adds.

Another strategy would be to show the patient a cardboard drawing of a clock and tape pills at the times when the patient will need to take his or her medication, she adds.

People who must experience something before they can truly understand it will need hands-on help.

For instance, a discharge planner could help them count out their pills and place these in a pillbox that's divided by days, Rogers says.

Those who learn through experience might return to the hospital, but this should be seen as an opportunity to make the discharge education stick, she says.

"Once they've experienced the problem, you can go back and show them another aspect of their health care," Rogers says.

Discharge planners also could ask patients how they could help them adhere to their medical regimen and appointments.

"You could say, 'You'll have to go back to your doctor, so what do I have to do to help you get back to that doctor?'" Rogers suggests. "Do I need to write it down for you or put it in your PDA?"

Another strategy is for discharge planners to have patients ask themselves these three questions:

1. What is my main problem?

2. What do I need to do?

3. Why is it important for me to do this?

"These three questions will lead to answers they can use when they return home," Rogers says. "Discharge planners should teach patients to ask these questions; otherwise, we'll see them back in the door again."

These various teaching tactics are important even when patients have high health literacy, Rogers says.

"I'm a nurse, and I'm a visual learner, so if someone rattles off stuff to me, I pull back and might not hear it," Rogers explains. "So even though we may have high health literacy, we still have the ability to learn in a specific way."

For Rogers, a more effective teaching style would involve a chart or chalkboard diagram, she notes.

"We need to pay attention to the patient, so while we're chatting with patients we can hear what they're saying back to us and we can figure out where they are," Rogers explains.

"If you're lecturing, and the patient is staring at walls, and if you ask him to teach it back and he can't come up with anything, then this patient probably is not a listener," Rogers says.

It would be time to switch tactics and use visual learning material, she adds.

"The point of all health literacy theory is to find out what the individual is all about," Rogers says. ■

Study: Deficits in discharge docs of transferred patients

Risk rises for patients on anticoagulation

Anticoagulation therapy is effective and common treatment for many hospital patients, but there's a high risk for certain patients, including those over age 70.[1]

It's crucial that discharge planning include thorough education to prevent adverse events, says **Esteban Gandara**, MD, a medical doctor and researcher at Brigham and Women's Hospital in Boston.

"We know that during the transition of care, a lot of adverse events can occur," Gandara says. "So we wanted to see if all patients were receiving all of the information."

Communication problems for patients receiving anticoagulation treatment might cause dosing errors, adherence problems, drug-drug or food-drug interactions, and these problems could be especially dangerous in patients who have a history of bleeding, diabetes, anemia, obesity, renal insufficiency, or who have alcohol or drug abuse issues.[1]

Trained medical residents, admitting physicians, nurse practitioners, and other medical professionals at subacute sites evaluated discharge documentation of a sample of patients who were discharged to the subacute sites. The patients were either receiving anticoagulation for treatment or for prevention of thromboembolic disease.[1]

The discharge documentation packets included discharge summaries, discharge orders, nursing instructions, care coordination, and physical or occupational therapy notes.[1]

The sample included patients at five hospitals in the Partners Healthcare System between March 2005 and June 2007. All of the patients

CNE *questions*

1. Which of the following strategies is necessary for preventing crises in transitions in care?

A. Find out what the patient's home environment is like
B. Educate patient about payer-imposed limitations on services
C. Anticipate and prevent adherence problems
D. All of the above

2. A recent study found that what proportion of high-risk adult patients discharged from a hospital were not referred to post-acute services despite their high risk for rehospitalization?

A. About one-quarter were not referred to post-acute services
B. About one-third were not referred to post-acute services
C. More than one-half were not referred to post-acute services
D. A little less than three-quarters were not referred to post-acute services

3. Which of the following describes the tool called a readiness ruler?

A. It's a drawing of a ruler on which patients write their pros and cons for taking their medication as prescribed
B. It's simple hand guide that answers patients' questions about their medication and treatment
C. It's a simple drawing of a ruler with a transition of colors from bright red to bright green. Patients are asked to describe how ready they are to make a change. Those who are not at all ready would select the bright red or zero at the far left of the ruler. Those who already are making a change would select bright green or 10 at the far right. Others will fall in between.
D. None of the above

4. It's important to assess each patient's health literacy, and one strategy is to ask patients a question that would help the discharge planner see if the patient understands the discharge education. Which of the following is a question that should be asked of patients?

A. What is my main problem?
B. What do I need to do?
C. Why is it important for me to do this?
D. All of the above

Answers: 1. D; 2. C. 3. C. 4. D

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 the **May/June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

SOURCE

For more information, contact:
- **Esteban Gandara**, MD, Brigham and Women's Hospital, Boston, MA. Telephone: (857) 492-5547.

were being discharged to a subacute facility, including any of 30 rehabilitation hospitals and skilled nursing facilities.[1]

"What we were looking for were physicians who were writing discharge summaries or who were giving instructions," Gandara says. "We decided to ask questions about what sort of information should be included, according to a group of experts."

The reviewers, who were trained, filled out a survey that outlined whether the documentation included all of the data elements necessary for continuing patient care.[1]

For example, the essential items for patients receiving warfarin included indication, Target International Normalized Ratio (INR) range, duration of therapy, last three INR values with dates, last three warfarin doses, recommended dosing until next INR testing, and provider or clinic conducting follow-up monitoring.[1]

Investigators found that the most common deficits in documentation for patients on warfarin were dosing and monitoring information, Gandara says.

Also, the warfarin patient documentation sometimes lacked the recent INR levels, and nearly 84% of the warfarin cases were missing one necessary piece of documentation.[1]

In patients who were receiving unfractionated heparin (UFH) or low-molecular-weight-heparin (LMWH), the most common deficits in documentation were duration of therapy and monitoring parameters.[1]

"We found that only 16% of patients had all the information they needed if they were on warfarin, and only half of the patients on heparin had all of the information that was needed," Gandara says.

The findings likely are the result of forgetfulness during the discharge planning process, Gandara speculates.

"Usually this is something we do at the end of care of patients, and sometimes it tends to be something we all forget," he explains. "It isn't something that people think about."

The study also found that when discharges from community hospitals were compared with discharges from academic medical centers, the community hospitals provided better documentation, Gandara says.

"One explanation we have is that academic medical centers had interns do the discharge summary, compared with community hospitals having trained physicians do these, who might know what's more important for a patient," Gandara says.

Gandara recommends that hospitals use an electronic discharge summary to help clinicians make certain they've included all of the necessary discharge documentation.

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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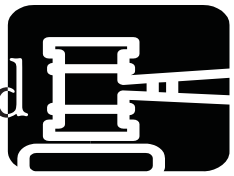
"Electronic discharge summaries can take about 16 minutes to do, and they are not paper-based, but can have print-outs," Gandara says.

Reference

1. Gandara E, Moniz TT, Ungar J, et al. Deficits in discharge documentation in patients transferred to rehabilitation facilities on anticoagulation: results of a systemwide evaluation. *Joint Comm J Qual & Pat Safety*. 2008;34(8):460-463. ■

For the Record



Know nuts & bolts of CMS Condition Codes 42, 43

The Centers for Medicare & Medicaid Services (CMS), of Baltimore, requires Condition Code 42 to be used when a hospital patient is discharged to home health services.

The home health treatment plan is unrelated to the inpatient stay.

However, Condition Code 43 is used when the hospital patient is discharged with home care services that do not begin until after the third day post-discharge.

Providers use both codes with the discharge disposition code 06, which is for patients who are discharged or transferred to home under care of organized home health service organization. ■

Hospital-acquired conditions explained by CMS

Hospital providers need to be fully aware of the new steps taken by the Centers for Medicare & Medicaid Services (CMS) to report and prevent hospital-acquired conditions.

For more than one year, hospitals have been required to report on their Medicare claims whether any of eight selected conditions were present when patients were admitted to the hospital, and since Oct. 1, 2008, hospitals have had to report on additional conditions, as well.

These Present On Admission (POA) indicators must be completed for every diagnosis on an inpatient acute care hospital claim.

CMS defines POA as those conditions that are present at the time the order for inpatient admission occurs, including conditions that occur during an outpatient encounter, including emergency department, observation, or outpatient surgery.

If patients at discharge have any of the reportable conditions that were not identified as POA, then the condition is considered hospital-acquired, according to CMS.

The conditions CMS has selected as reasonably preventable include:

* Leaving a foreign object in a patient;
* Having an air embolism enter patient's blood stream;
* Giving patient wrong blood in transfusion;
* Falls and trauma;
* Fracture. ■