DISCHARGE PLANNING
ADVISOR

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IN THIS ISSUE

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Special Report: *New models in care transitions*

Transition in care plans should include strong DP support

HC trends indicate greater need for DP

The 21st century model for health care includes patient-centered care, focusing on quality, efficiency, and actions that have a long-term positive impact.

Hospitals that embrace this model will survive and, perhaps, thrive, experts say.

Even if the model has no short-term economic benefits, it's the right thing to do because of the problems patients and health systems face due to a disjointed system in which a single patient might see more than a dozen physicians to treat multiple chronic illnesses, experts say.

Recent health care projections predict that the number of people with multiple chronic conditions will increase to 81 million by 2020.[1]

"If you keep the old model, the patient loses, so we're interested in coalescing around patient-centered care," says **Elizabeth J. Clark**, PhD, ACSW, MPH, executive director of the National Association of Social Workers in Washington, DC. Clark is a member of the National Transitions of Care Coalition (NTOCC) advisory task force.

The NTOCC is a group of organizations working to improve care transitions and place the focus on patient-centered care. The organization provides a variety of educational material and tools for patients, caregivers, and providers on its web site at www.ntocc.org.

The pressures that bear down on families and health care providers will continue, so they need to be addressed or care transitions won't function as they should, experts say.

American demographics are causing some of the changes.

For example, Americans are living longer, so family caregivers often are quite old as well, notes **Cheri Lattimer**, RN, BSN, executive director of the Case Management Society of America in Little Rock, AR. Lattimer also is a member of the NTOCC advisory task force.

"Where we've had three generations still living, we now have five and six generations of a family," Lattimer says. "That means there's a mother living to 101, and she has a daughter in her 80s and grandchildren in their 60s."

These elderly multi-generations can lead to care breakdowns when a frail and sick relative is sent home with little health system support.

"How do we restructure how we deliver health care long-term?" Lattimer says. "Think about the individual who is severely ill and how the family member is going to deal with all of the person's needs."

Hospital discharge planners might see a new trend in coming months as the recession takes its toll on how people manage their health, suggests **Lanis Hicks**, PhD, a professor in the department of health management and informatics at the University of Missouri in Columbia, MO.

"With an economic downturn, what we begin to see is fewer patients admitted for any kind of elective procedures," Hicks says. "As people lose insurance coverage because they're unemployed or their employers decrease benefits on insurance packages, then people wait longer to access health care."

So hospitals' patient populations will continue the trend of being sicker and more frail, which means better care transitions will be crucial for reducing repeated emergency department (ED) visits and improving patients' long-term health. **(See story on current economic pressures on hospitals, p. 17.)**

One discharge planning area that all hospitals should focus on and improve is medication management, says **H. Edward Davidson**, PharmD, MPH, a partner with Insight Therapeutics, a medication management and research firm in Norfolk, VA. Davidson also is an assistant professor at the Glennan Center for Geriatrics and Gerontology at Eastern Virginia Medical School in Norfolk. Davidson also is a member of the National Transitions of Care Coalition advisory task force.

"The quality of medication review, in my experience, is still pretty poor in some instances," Davidson says. "This is a key transition of care issue, whether the patient's going home or to a nursing facility or to an assisted living facility or transitional care hospital."

For instance, the transition of care team needs to keep a patient's spouse, family member, or other caregiver in the loop with regard to discharge planning and medication needs, he says.

"Hospitals need to involve family members and personal care advocates to a greater degree," Davidson says.

"There needs to be an advocate," Davidson explains. "There needs to be someone else who knows when these transitions occur for the older patients who are more likely to have functional or cognitive deficits that impair their ability to speak up for themselves about their medication."

Patients on medication regimens for chronic diseases sometimes are hospitalized with an acute illness, and then their medication is changed significantly, he notes.

"Then they go home, and the family has new

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marching orders that are discordant with what they were doing previously, so the prescriptions in their old bottles don't match up," Davidson says.

So the patients and families will adjust to the changes as well as they can, and then the patient is rehospitalized, and the medications change again, further confusing them, he adds.

Patients, caregivers, and medical providers need help with monitoring all medications patients are on and any changes made to these, he says.

A tool that will help with this is a personal medication list. **(See sample information from NTOCC medicine list, p. 17.)**

"We feel like this needs to be an accurate, dynamic document that patients have access to," Davidson says.

Ideally, the document would be updated each time the patient has a change to his or her medication regimen, he adds.

The nation's health care providers and advocacy organizations are focusing on transitions of care issues, which many see as a crucial element of health care, Lattimer says.

Research has shown that transitions can have adverse outcomes for patients and lead to dissatisfaction among providers, Lattimer says.

Several groups are highlighting care coordination this year, including The Joint Commission On Accreditation of Healthcare Organizations of Oakbrook Terrace, IL, which has published on its web site at www.jointcommission.org, its 2009 National Patient Safety Goals for a variety of health care settings, including ambulatory health care, behavioral health care, critical access hospital, disease-specific care, home care, hospital, laboratory, long-term care & Medicare/Medicaid certification-based long term care, and office-based surgery.

Also, the National Quality Forum (NQF) endorsed in 2006 a definition and framework for care coordination and now is seeking nominations for a steering committee and technical advisory panels for a project to endorse a set of preferred practices and performance measures in care coordination.

Also, the Centers for Medicare & Medicaid Services (CMS) has been pushing for greater care coordination. In January 2009, CMS announced sites for an Acute Care Episode demonstration that has the goal of using a bundled payment to align hospital and physician incentives and lead to better quality and efficiency in care delivery.

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"There's a push for organizations to improve transition in care coordination and to provide resources to patients, case managers, and all providers, and identify performance measures that support that," Lattimer says. **(See story about more HC integration, p. 16.)**

"Case managers, nurses, and social workers often are assigned to medically-complex patients, who bring all of the issues of care coordination, because they require more resources," she says. "That's why you're hearing we'll need more case managers."

An example of care coordination that might serve as a model for the future is a community program called Kentucky Homeplace in Hazard, KY, Clark says.

Kentucky Homeplace is a program of the University of Kentucky's Center for Rural Health. With staff hired from the communities the program serves, its goal is to help people with chronic illnesses find health care services to prevent their conditions from becoming life-threatening.

"They don't assume people have the resources — they find the resources," Clark says. "It's gotten great funding from state government, because they see how valuable it is."

For every dollar spent for Kentucky Homeplace's program, the community benefits three- or four-fold, she adds.

"They work with hospital discharge [planners]," Clark says.

If a patient doesn't have the money to make a co-pay on medications, then the program will get the patient the drugs. The program's family health care advisors also help educate patients about their diseases and provide reinforcement in patients' homes, she says.

"If they can do that kind of program in Appalachia, then why can't we do it?" Clark adds.

Reference:

1. Anderson, G. "Better Lives for People with Chronic Conditions," Partnership for Solutions. 2001. Available at http://www.partnershipforsolutions.org/statistics/prevalence.html. Last accessed November 17, 2008. ■

Health care services are becoming more integrated

Experts see greater unity

In some ways, the direction health care is heading could be seen as a back-to-the-future scenario.

Discharge planning may return to its roots as a team process.

"Years ago, when I started out, we worked as a team and met once a week to discuss discharging patients," says **Elizabeth J. Clark**, PhD, ACSW, MPH, executive director of the National Association of Social Workers in Washington, DC. Clark is a member of the National Transitions of Care Coalition (NTOCC) advisory task force.

"We had a nurse, social worker, and sometimes a clergyman," Clark recalls. "That was when length of stay (LOS) was much longer, and you had a full component in the hospital setting."

The discharge team did a good job of returning patients home, she adds.

"Visiting nurses would come in the hospital and meet with us and do a home assessment," Clark says. "Then people would leave the hospital, and their transition was pretty good."

Years of cutbacks at hospitals forced cost-cutting changes, such as putting the discharge planning role on the shoulders of nurses, she adds.

"They decided nurses could do everything, which is unfair to nurses because they have a lot to do," Clark says. "They kept cutting back because of financial efficiency, and that's been a really unfortunate way to focus on good, patient-centered care."

But over time, health care researchers and experts have noticed a trend of patients who are discharged without adequate resources returning to the hospital within weeks. The long-term financial efficiency is compromised by a model in which discharge planning is not a priority.

"I don't think many of us would say it's very efficient to have someone go home today and then be back in the hospital in two weeks," Clark says.

"They don't like to include education and prevention in their efficiency measures," she adds. "But if they don't do a better job of educating the patient and caregiver, then they're not going to be able to stay in the home."

There are models of collaborative discharge planning and transitions of care teams that offer hope, Clark says.

"It's like going back to the future," Clark says. "In my mind, we're going back to the kind of care we used to give, but we're doing it on an outpatient basis instead of an inpatient basis."

What could increase momentum back to preventive care and more focus on the discharge planning process is President Obama's focus on long-term improvements and prevention, Clark says.

"The new president has come out very strongly in favor of prevention, and that's the first time we've heard a president talk about prevention in terms of their mandate," she says. "We have always known how to do good health counseling and prevention, but nobody has ever been interested in it."

Medicare's reimbursement style should be changed to make it easier on patients and providers, as well as to make the process more efficient, Clark suggests.

For instance, one current barrier is a reimbursement system that allows only one provider to be paid per patient per day, she says.

"If you come in to see one doctor in a day, then if you want to see a dietitian, you'll have to come back another day," Clark says. "It places a tremendous burden on the patient."

These types of barriers make it more challenging for health care providers to collaborate.

Another change that could cause care collaboration and integration involves pending health care workforce shortages.

There are workforce shortages in health care across the board, and as those shortages become

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more critical, there will be more health care integration, says **Cheri Lattimer**, RN, BSN, executive director of the Case Management Society of America in Little Rock, AR. Lattimer also is a member of the NTOCC advisory task force.

"I honestly believe our shortages will drive us to unite," Lattimer says. "We see a lot of case management teams where nurses and case managers work together."

And the next push will be to increase the involvement of families and caregivers in the whole process, she adds.

Discharge planning teams will need to improve patient and family education and learn more effective communication strategies, Lattimer says.

Communication issues to consider

They'll have to consider these communication issues, she adds:

• What is the health literacy of the patient and caregivers?

• Do the patient and family understand medical terms?

• Is English their primary language?

• Can they comprehend English?

• Did we write the discharge plan patient literature in medical jargon?

"There's a significant recognition of what's good communication and how we can develop that," Lattimer says. "The patient and family might never ask questions while they're in the hospital, and then they might miss their follow-up doctor visit and end up back in the emergency room." ■

NTOCC has patient medicine list online

2-page tool can be downloaded

The American Society of Health-System Pharmacists (ASHP) and the ASHP Research and Education Foundation have developed a 2-page tool called "My Medicine List," which can be downloaded from the National Transitions of Care Coalition (NTOCC) web site, www.ntocc.org.

The tool includes a page where patients list their name, birth date, phone number, e-mail, emergency contact, allergies, and medication problems.

It also provides instructions for how to use the list and a chart for writing down medications with columns for the following:

• "Drug name (brand name, generic name, dose);"

• "This looks like";

• "How many?"

• "How I take it";

• "I started taking this on";

• "I stop taking this on";

• "Why I take it";

• "Who told me to take it."

There also are rows with this list:

• "In the afternoon, I take:"

• "In the evening, I take:"

• "Before I go to bed, I take:"

• "Other medicines that I do not use every day:" ■

Economic pressures increasing for patients

Efficiency, collaboration are important

As the economy worsens and the rolls of the unemployed and uninsured increase, hospitals can expect some hard times, as well, an expert says.

Hospitals' economic pressures will result from several directions:

1. Patients will be sicker with more comorbidities. "People with chronic illnesses or generally poor health will wait until they have an economic crisis to seek help," says **Lanis Hicks**, PhD, a professor in the department of health

management and informatics at the University of Missouri in Columbia, MO.

Sicker patients are less able to handle their comorbid conditions when they're discharged, Hicks notes.

"As we try to get patients out of the hospital and into different step-down levels, we're going to need somebody to help coordinate all of these services that are needed and work with providers and patients," she explains. "We need to accommodate the patient and also increase efficiency."

Discharge planners will be a crucial part of this process, and their work could extend to the home environment.

Without DPs or case managers, how will health care providers know whether patients have the basics needed in their home environment in which to maintain their health, Hicks asks.

2. States will cut Medicaid. "Their condition won't be easy to take care of, and at the same time states are cutting Medicaid payments and are cutting eligibility and cutting the amount they pay per patient," Hicks says. "So at a time when the demand is increasing on hospitals, they're getting paid less."

This puts economic pressure on cutting services that are not reimbursed, including preventive services, Hicks says.

But this would be a long-term mistake.

Discharge planning, which can help prevent future medical crises, should be expanded under these conditions — not cut.

"As we start focusing on the management of chronic conditions rather than delivery of acute, episodic care, then this type of activity is going to increase," Hicks says. "We have people coming in with multiple conditions, so how do we ensure as we treat them for a single condition that we don't let the other conditions worsen?"

3. Insurers will delay payments. The economic pressure also means that insurance companies, which now have a declined financial status, are dragging out how long it takes them to pay a bill, and hospitals will have a more difficult time getting loans to meet their payrolls, Hicks adds.

This scenario is frightening and painful, she acknowledges.

"But there are also ways we can do things to be more efficient and more effective," Hicks says.

The key is for hospitals not to view the recession as a short-term problem, where if they just hang on, things will get better next month or the month after, Hick advises.

SOURCE

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"It will be painful in the short term, but I think we can use this as an opportunity to look at it and say, 'Maybe we don't need all of this technology, the newest and fastest all the time,'" Hicks says. "Does it really provide us with benefits equal to its costs?"

If hospitals do some soul searching and cut costs where it's less necessary, then they could come out of the recession as a stronger system, Hicks adds.

Hospitals also can improve collaboration and cooperation among different providers, Hicks says.

This is a process that is helped by a strong discharge planning team.

"As hospitals are trying to discharge patients, they need to work with either home health agencies or nursing homes to admit patients," Hicks says. "They can't take the attitude of 'This is no longer our problem.'"

The discharge planning process must focus on making sure the next provider receives all of the patient's medical information, including medication prescriptions, she adds.

Communication will be key, and this is where an electronic medical record could make the discharge process more efficient and safe.

"It would certainly help if everyone was electronic," Hicks says. "But it also has to have a standard platform, a system where when I enter information the next person down the line can read that information."

Many facilities do not even have standard electronic communication within their own systems, she notes.

"Doing this would require government grants and maybe national requirements," Hicks adds.

Or private industry could make this standardization happen through a monopolistic approach, similar to what Microsoft did with personal computers.

"It would have to be someone who has enough market power to say, 'Yes, this is what we're going to do,'" Hicks says.

Despite the economic crisis, Hicks remains optimistic: "We hear a lot of doom and gloom reactions right now, and I think definitely we are facing in the health care industry a lot harder times than we've had in the past," she says.

But the key is to see these economic pressures as an opportunity to review processes and find ways to improve both quality and efficiency, Hicks adds. ■

Improving discharge without high costs? Try a CBO

AIDS group helps local hospital with DP

It's in a community's best interest to have high-quality discharge planning. This is why a community-based organization (CBO) in New York City, has formed a collaboration with a local hospital to assist when HIV/AIDS patients are being discharged.

"We understand the relationship between programs with different expertise and similar consumers to ensure a full range of services," says **Sharen Duke**, MPH, CEO of AIDS Service Center (ASC) in New York City.

ASC has formed numerous partnerships with hospitals and medical providers as part of its mission to ensure a full range of services for its clients, Duke says.

"We have a case management program that works with New York Presbyterian Hospital," Duke says. "It's funded through Medicaid and targets people who are living with HIV, providing both an assessment and escorts to medical appointments."

With HIV/AIDS patients' consent, Presbyterian Hospital physicians ask ASC to be part of the hospital's inpatient discharge planning team, she says.

"This is unprecedented for an outside entity to be part of inpatient discharge planning," Duke adds.

The program started in April 2006, with a single patient, says **Susan Olender**, MD, instructor of clinical medicine at Presbyterian Hospital.

Leaders at the hospital's AIDS Center had long observed that HIV patients were frequently readmitted to the hospital when they should be engaging in outpatient care, Olender says.

"There are a lot of AIDS-related, preventable illnesses if only people could connect to their outpatient services," Olender says. "Even if you have advanced HIV disease, if you take a daily antibiotic, you can prevent pneumonia and meningitis."

When patients failed to engage in outpatient care there were outcomes of significant morbidity, mortality, and inpatient costs, she adds.

Some leaders at the hospital already knew Duke and were familiar with ASC's services to this population. So, they hatched the idea to have ASC assist with discharge planning for patients who were considered at high risk of failing to access outpatient services.

"The formal process is, we have these rounds in the inpatient setting with the social worker, and we keep our ears out for people who might be at high risk of failing to follow up," Olender says. "We ask patients whether they'd be interested in having a case manager help them so they won't have to come back to the hospital, and when people say, 'Yes,' we call ASC."

An ASC case manager then will meet with the patient before discharge and review the patient's discharge plan. The case manager will help the patient pick up medication, make a connection with all outpatient visits, and update the hospital team in weekly conference calls, Olender says.

Before the patient leaves the hospital, the ASC case manager will work on an assessment of the patient's needs, says **Kim Atkins**, chief financial officer of AIDS Service Center.

"We take on the hardest cases to deal with," Atkins says. "These are the people who drop out of the system and then come back to the hospital."

These high-risk patients often have unstable housing and have mental health problems, he adds.

"We develop a plan and identify the patient's concrete needs, setting up manageable goals for the individual," Atkins says. "Then we're with the patient right after discharge to see where they're going and to make sure they're situated."

From a case manager's perspective, the work is very intense, says **Cynthia Rossi**, MA, senior case manager with AIDS Service Center.

"We work with a goal of stabilizing the client," Rossi says.

For example, a physician calls Rossi about a patient who will be discharged in a couple of days. Rossi will visit the patient and do an intake

in the patient's hospital room and describe the program to the patient, explaining that the main goal is to help the patient make that leap from inpatient care to outpatient care. **(See story outlining the ASC case manager's job in discharge planning, p. 21.)**

"It's really overwhelming to the client, because there's so much information to absorb," Rossi says. "They have four to five medical appointments in the first week after they're discharged."

The hospital-CBO collaboration for transitioning patients to the community hasn't included a thorough collection of data on the program's impact, but Olender says she's certain the program has provided patients with better care.

For example, before the first patient was treated in the program, he had an alcohol abuse problem and was regularly missing medical appointments, Olender recalls.

"ASC case managers sought him out and brought him in just in time for a treatment of lymphoma," Olender says.

"The case manager tried and tried week after week and brought him in and got him into supportive counseling," she adds. "So he was treated for HIV, treated for cancer, and this resulted in remission of the cancer, and he got his own apartment."

The man occasionally still drinks, but his case is a success story, Olender adds.

ASC and Presbyterian Hospital are working on ways to make their relationship and the structure of the program stronger, Atkins says.

"We're using existing resources to do this, but we're limited by that," Atkins says. "We can't build it the way we want or make it better without additional resources, so we're partnering with others to find those resources that will make it more effective."

Benefits of collaborating with a CBO

One of the major benefits of collaborating with a CBO during the discharge process is that these outside organizations have more knowledge about resources available to patients in the community than do many hospital discharge teams, Olender notes.

"I've learned that ASC has excellent knowledge of housing resources in New York City," she says. "They also have a sense of framework, knowing what people's options are and where people can go if they're homeless or marginally housed."

Some of the issues the ASC case manager deals with are ones that occur immediately at discharge, and others are basic needs that must be met before the patient can progress to the next level of medical care, Olender adds.

While HIV disease is a good candidate for this type of discharge planning model, there are other chronic diseases for which it would work as well, Olender says.

"A whole crop of people are talking about how to create a model that's less about inpatient care and more about meeting people's outpatient needs, as well," she explains. "There appears to be some interest in trying to replicate the model to some other chronic diseases."

For instance, Olender has worked with dialysis patients, who are another group who need to be compliant with their medical treatment or they'll be readmitted to the hospital.

"I remember seeing patterns of patients coming in over and over," Olender says.

"You set up your discharge plan, and then you shrug your shoulders when they come back in with the same pattern," she adds. "But some need of these patients wasn't being met, and the idea was whether it would be possible to get someone to follow them around as outpatients, helping them help themselves."

For other chronic disease populations, the problem with the model would be finding resources, because public funding is different for HIV services, Atkins says.

The model makes sense from a holistic health

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care perspective, because society saves money when the high-risk patients stop being frequently admitted to the hospital.

"We've seen that preventable illnesses are taking up a lot of resources on the inpatient side, so there is definitely a need to shift care to the outpatient setting so that serious diseases can be prevented," Olender says.

"In a review of inpatient AIDS cases, physicians found that 29% of admissions on HIV service were due to preventable causes, and these admissions accounted for approximately 70% of HIV care inpatient dollars," Olender adds.

However, there also are logistical barriers to the model, such as finding time for team conference calls. "We've dealt with other medical providers who haven't figured out how to overcome barriers internally with inpatient and outpatient social work services," Atkins says.

But it's important to stay committed to collaborative models that work on preventing hospitalizations, because care coordination makes for better care, he adds. ■

Hospital, community organization's DP model

CMs help with daily needs & doctor visits

When high-risk HIV/AIDS patients are about to be discharged from Presbyterian Hospital in New York, physicians will call an outside organization called AIDS Service Center of New York for help with the transition in care.

"It's a phenomenal service for people who are at risk of falling out of care," says **Sharen Duke**, MPH, chief executive officer of AIDS Service Center (ASC).

"We provide the additional support and social connection that makes the difference between a patient getting continued medical care and falling out of medical care," Duke says.

An ASC case manager answers the physician's call to meet with a hospitalized patient. She visits the patient before discharge and asks questions to find out what issues are most important to that patient's care in the community, says **Kim Atkins**, chief financial officer of ASC.

The case manager will meet with the patient for about an hour, says **Cynthia Rossi**, MA, senior case manager for ASC.

"We want to see which is the first priority," Atkins says. "Is it substance abuse, mental health problems, or meeting basic needs?"

The case management team's caseload is about 15 to 20 clients, Rossi says.

The key is to find out what that person will need as soon as he or she is discharged from the hospital, and the case manager will figure out how to meet those needs, he says.

"We'll get them in a shelter if housing is a major issue, and we'll make sure they keep their doctor's appointments," Atkins says. "The patient's basic life issues have to be dealt with, and that's what the case management team does."

Before ASC formed the collaboration with the hospital, the hospital's discharge planners would try to meet patients at a first scheduled outpatient visit, but the patients wouldn't show up, Rossi says.

"That's the big reason why the program was implemented, because of the loss of care," Rossi says. "We deal with people who are hard to deal with and who don't want the medical care."

Here's how the discharge planning collaboration works:

1. Case manager meets with patient.

When the physician calls the ASC case manager, she meets with the inpatient social worker and obtains the patient's paperwork, Rossi says.

"They give us the discharge letter of what the patient needs to do in two days," she adds. "Then we go across the street to the outpatient HIV clinic, and the social workers there give us the paperwork we need, saying, 'This is what we discussed, and this is what needs to be done.'"

The hospital physician will speak with the patient about the transition in care program. Then, armed with the HIV clinic's care plan, the ASC case manager will meet with the patient and conduct an intake, Rossi says.

The intakes typically are done two days before the patient is discharged, she says.

Some patients express reluctance to having someone follow them into the community, but Rossi offers them reassurance.

"We've had so many successes with it, people who didn't want it in the beginning, but now they're on the track to better health," Rossi says.

Also, patients sometimes are concerned about confidentiality and privacy issues. They might not want someone to pick them up at their homes, and these obstacles have to be resolved, she notes.

Rossi's main marketing pitch to patients is as follows: "We know you need medical care, but what else do you need? We want to help you with the other things you need so that nothing gets in the way of the kind of medical attention you need."

The key to buy-in is to highlight the kind of help that the HIV/AIDS patients typically need and desire, such as helping them link with a food pantry and finding housing, Rossi says.

"We get all of that done to get them to fully commit to HIV care and medical attention," she explains. "That's what works very well for us."

For high-risk HIV/AIDS patients, the case manager needs to do a lot of hand holding, Rossi says.

"We tell them that after we get everything else stabilized in their lives, then we'll walk them through everything," she explains. "We'll pick them up, stay with them during the clinic appointment and explain medical terms to them."

The case manager sometimes needs to calm down patients when they become impatient or anxious.

"We tell them, 'Relax, you have one more day of this,' and after some calming down, they're very willing to get it over with," Rossi says.

One component of the program's success is the collaboration between the ASC case manager and the hospital social worker, Atkins says.

"At discharge, the social worker and case manager discuss and agree on what is the most important thing the patient will do," Atkins says.

This is more coordinated than other models, where community advisors work with hospital social workers, because both disciplines share the same objectives, he notes.

"We're talking and sharing what our sense of priorities are, and we're working on this together," Atkins adds.

2. Prepare for the patient's discharge.

"We start off and make clinic appointments for the patient," Rossi says. "We do the legwork ourselves, put them on the calendar and bring it with us wherever we go."

The case manager will tell the patient when his or her appointments are scheduled and reassures the patient that the case manager will be there too and make sure they understand what's going on.

Rossi tells patients: "If you have any concerns, you should stop and ask me, ask the doctor; hopefully, it will go as you want it to go."

Based on the initial assessment of the patient's

CNE *questions*

5. Researchers and health care trend experts note that the number of people with multiple chronic conditions is on the rise. What do health care projects predict their numbers will be in 2020?

A. 29 million
B. 42 million
C. 81 million
D. 123 million

6. As discharge planners seek to improve their communication and education with patients, which of the following questions might they consider?

A. What is the health literacy of the patient and caregivers?
B. Do the patient and family understand medical terms?
C. Can they comprehend English?
D. All of the above

7. Presbyterian Hospital in New York City has formed a unique collaboration for HIV/AIDS patients being discharged into the community. What is it?

A. Discharge planners will meet with AIDS clinic social workers to discuss the patient's care
B. Physicians will call an outside organization called AIDS Service Center of New York for help with the transition in care, and the organization helps patients stabilize their lives and make their clinic appointments
C. The hospital hires an investigative firm to find patients who do not return to their first post-discharge clinic visit
D. None of the above.

8. Which of the following might impact hospitals financially?

A. People will wait until very sick and have comorbidities.
B. States will cut Medicaid
C. Insurers will delay payments
D. All of the above

Answers: 5. A; 6. D; 7. B; 8. 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 2009** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

SOURCES

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needs, the case manager will begin to look for community resources the patient might need.

If housing is a problem, then the case manager might help the patient complete a housing application.

For HIV/AIDS, the HIV/AIDS Services Administration is a one-stop shop with assistance for housing, food stamps, and other public assistance, Rossi notes.

"Most of the time we pick up the patient from the hospital and take them straight to the HIV/AIDS Services Administration," she says.

If the case managers don't meet patients at the hospital at time of discharge, then it might take a while before they can track them down again, Rossi says.

"That's our biggest hurdle — locating somebody," she says. "We do investigative work when we do intakes and ask them where they hang out."

Case managers also might check local methadone programs and repeatedly visit their homes or hangouts, she adds.

3. Work with patient for long-term disease management.

The patients' HIV medications are distributed at the HIV clinics, which is where the patients go each week to have their viral load checked and to pick up the antiretroviral drugs, Rossi says.

The case managers go with patients on these visits. Once the patient's viral load is undetectable, which indicates the patient has been compliant with his or her medication regimen, then the visits are spaced to once a month. If the patient's medication adherence remains good, then the visits will be spaced to once every three months, Rossi explains.

Another long-term management issue involves comorbidities, including cancer.

"We have a lot of people who have cancer, and that requires more appointments than the HIV treatment does," Rossi says. "They might have to see a radiologist or receive chemotherapy every day."

For instance, one HIV patient who has cancer has chemotherapy five days a week, as well as less frequent HIV clinic visits, she says.

"We provide more support for her, making sure she knows her appointments, making sure

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. ■

COMING IN FUTURE MONTHS

- Education technology can assist at discharge
- Hospital's ED uses triage to improve discharge process
- Improve medication reconcilitation process
- Patients want discharge follow-up, study shows
- QI program reduces 1-day stay payment errors

she has food, making sure the home health services show up when scheduled, making sure she's comfortable," Rossi explains.

Part of the case manager's job also involves keeping hospital staff informed of patients' cases.

"We call on a bridge line every Wednesday around 3:30 p.m.," Rossi says. "I speak with the psychiatrist, social workers, substance abuse counselors, physicians, and sometimes the treatment adherence team." ■

Know CB requirements when referring to PA care

Discharge planners and others might find the rules confusing with regards to consolidated billing (CB) under the Balanced Budget Act (BBA) of 1997. This may be particularly true when patients are discharged to skilled nursing facilities (SNFs) and home health services.

The Centers for Medicare and Medicaid Services (CMS) has provided descriptions and clarifications about how CB works for these post-acute services at these web sites:

- www.cms.hhs.gov/SNFPPS/05_ConsolidatedBilling.asp
- www.cms.hhs.gov/HomeHealthPPS/

Here is a summary of what CMS says:

Changes were made to original CB legislation: The original CB legislation in the BBA was modified over the years. Now the provision regarding SNFs applies only to services that a skilled nursing facility resident receives during a covered Medicare Part A stay. The only exceptions include physical, occupational, and speech-language therapy, which remain subject to CB regardless of whether the resident receiving the services is in a covered Part A stay.

Excluded services are billed separately to Part B: Services excluded from SNF CB are billed separately to Medicare Part B, but the bills still must contain the SNF's Medicare provider number. The services that are excluded include these:

- Physicians' services that include furnished to SNF residents, although the technical component of physician services is subject to CB and must be billed to and reimbursed by the SNF;
- Physician assistants, nurse practitioners, and clinical nurse specialists working in collaboration with a physician or under a physician's supervision;
- Certified nurse-midwives, qualified psychologists, and certified registered nurse anesthetists;
- Part B coverage of home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;
- Part B coverage of epoetin alfa (Epogen) for certain dialysis patients;
- Hospice care, an ambulance trip that conveys a beneficiary to the SNF for the initial admission, and physician "Incident To" services.

Some specific outpatient hospital services also are excluded: Some hospital services are so intensive and costly that CMS has excluded them from SNF CB.

Also, durable medical equipment is excluded from CB. ■