

# Patient Education Management™

For Nurse Managers, Education Directors, Case Managers, Discharge Planners



## Re-Engineered Discharge Program covers all the details for safe discharge

*Patients discharged with no doubt about the steps they need to take for recovery*

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It is vital for patients to receive complete information at discharge. Yet studies have shown the average discharge instruction is eight minutes, and there is no discharge checklist that covers what needs to be completed before a patient goes home, says **Brian Jack**, MD, associate professor and vice chair with the Department of Family Medicine at Boston University School of Medicine/Boston Medical Center.

To remedy this problem, Jack and a team of researchers developed a multifaceted program to educate patients about their post-hospital care plans. It is called the Re-Engineered Hospital Discharge Program, or RED, and was tested through a randomized controlled trial funded by the Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD.

The study found that the cost of care for patients who received complete information was \$412 less on average than those who did not. Fewer hospital readmissions and emergency department visits were the reason for the lower costs.

Although the study results were published in 2009, work on a complete

### EXECUTIVE SUMMARY

Good patient instruction is important for a safe discharge from the hospital, but what exactly does that entail? Researchers at Boston Medical Center determined that a good plan had to contain certain components. They used this information to construct the Re-Engineered Hospital Discharge Program — then tested it in a randomized controlled study to determine how well it worked.

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discharge program began about five years earlier when Jack and his team of researchers submitted a grant application for improving patient safety by intervening at the discharge process.

“One of the big elements in safety is transitions in care, or going from one part of the health system to another — for example, from the emergency department to the hospital floor. One of the biggest transitions in care is being discharged from the hospital,” explains Jack.

The grant review team wrote back that while the researcher’s idea was interesting, no one had ever characterized what the hospital discharge is exactly. Therefore, a year and a half was spent characterizing the discharge process in detail. A

process map was created, and a group of key leadership from throughout the medical center was asked to think about how to redesign it. They were asked what hospitals should be able to deliver to people before discharge.

From that process, the team came up with the principles of the re-engineered discharge and assembled a list of 11 components. The components include such steps as “make appointments for clinician follow-up and post-discharge testing with input from the patient regarding the best time and date of the appointment” and “confirm the medication plan.” (The complete list also can be accessed and printed at [www.bu.edu/fammed/projectred](http://www.bu.edu/fammed/projectred)).

The education that takes place is more than details on the diagnosis or medication regimen; it includes details on the follow-up care that must be completed, such as medical tests needed once the patient returns home. In addition, information is organized in such a way that it is easy for patients to follow.

“In the hospital, we need to organize the information for patients and put it into a format that they can understand. Then, we need to reinforce that information when they go home, and that combination of activities was very effective in the outcome measure,” says Jack.

### **Providing complete information**

During the study, one group of patients underwent a standardized discharge intervention, and the other group did not. This intervention included patient education, comprehensive discharge planning, and post-discharge telephone reinforcement. (For more details on the study visit [www.bu.edu/familymed/projectred](http://www.bu.edu/familymed/projectred).)

Nurse discharge advocates were trained to deliver the in-hospital intervention. A training manual was developed to teach nurse discharge advocates all aspects of RED. The manual has detailed scripts and simulated practice sessions. (Details on the training manual can be found at [www.bu.edu/fammed/projectred/index.html](http://www.bu.edu/fammed/projectred/index.html)).

Adhering to the elements of RED, the nurse collected all necessary information from the hospital care team and the patient and entered it into a software program to create the after-hospital care plan.

Each individualized plan contained contact information on the medical provider, dates for appointments and tests, an appointment calendar, a color-coded medication schedule, a list of

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For questions or comments, call **Susan Cort Johnson** at (530) 256-2749.

## SOURCE

For more information about the implementation of RED, contact:

• **Brian Jack**, MD, Associate Professor and Vice Chair, Clinical Director, Lesotho Boston Health Alliance, Department of Family Medicine, Boston University School of Medicine/Boston Medical Center. Telephone: (617) 414-4465. E-mail: brian.jack@bmc.org.

tests with pending results at discharge, an illustrated description of the discharge diagnosis, and information on what to do should a problem arise. This care plan was printed and spiral-bound for each patient. (To obtain a sample copy of the after-hospital care plan, click on the tool-box icon on the web site.)

During the trial, the nurse discharge advocate taught the after-hospital care plan to the patient. Patients didn't have to memorize the information. They just had to know where it was located in the care plan. To test competency following education, the nurses asked the patients when an appointment was scheduled with a particular doctor or how many times a day they must take a particular medication. All the information was in the care plan, and they could answer the question by flipping to the correct page.

"The idea is that a lot of complex care happens in the hospital, and when patients go home, they are expected to take care of themselves. But we don't really do a good enough job teaching them what it is they are supposed to do, and there is lots of data to show that is the case," says Jack.

The final step in the care plan was a follow-up call from a clinical pharmacist two to four days after discharge to reinforce the information and answer any questions patients had. The interview process was scripted.

One important element of the care plan was its design. The format was created with good health literacy principles in mind. For example, the name of the medication was written in large type, and the daily regimen was divided into sections — morning, noon, evening and bedtime — so it was easier to follow. A page that listed doctor appointments was then color-coded to a calendar.

Why would hospitals want to adopt the Re-Engineered Discharge program? There are many reasons, says Jack. It surpasses the standards set

by The Joint Commission in Oakbrook Terrace, IL. It decreases the need for re-hospitalization and visits to the emergency department; it greatly improves patient and family satisfaction; and it documents all the information people are given. ■

## Mental Health Month theme is dealing with stress

*Teach helpful habits to develop in advance*

One way people can help prevent certain mental and physical health problems is to learn how to reduce stress and better cope with it when it does occur.

Learning the best ways to deal with stress is particularly valuable in uncertain economic times when people face possible job loss or foreclosure on their home.

That's why Mental Health America, based in Alexandria, VA, is launching a campaign during May 2009 — Mental Health Month — that focuses on the issue of stress and how to deal with it.

Successfully coping with stress is much more than learning techniques to use during stressful times. It also entails learning good mental health strategies to practice on a regular basis, so it is easier to deal more positively with the challenges and adversity of life.

People are immunized to ward off diseases, yet they are not taught how to promote mental health, says **Diana Morales**, MPH, vice president of public education for Mental Health America. There are lifestyle strategies that help people deal more positively with challenges and adversity when incorporated on a regular basis.

What can people do to prepare for stressful times? The research shows that people who have a strong social support system do better during difficult times, because they have people who

## EXECUTIVE SUMMARY

May is Mental Health Month, and the focus this year is stress. Good overall health includes a lifestyle that promotes mental health.

care about them and support them, says Morales. These friends and family members provide someone with which to talk.

“You can’t make the situation go away, but the support from friends and family and other people who care helps a great deal,” explains Morales.

Also being engaged in one’s community helps reduce overall stress and promotes mental health. It gives people a greater sense of purpose and meaning in their lives. Community engagement might be accomplished through volunteer work, says Morales.

Getting enough sleep is important for good mental health, as well as physical activity, such as walking, says Morales.

When these factors are a part of a person’s lifestyle, he or she is better able to cope. For example, physical activity can help reduce the anxiety caused by a stressful situation.

There are several coping strategies people can use when a stressful situation occurs. Morales says research shows that relaxation techniques, such as meditation, help reduce stress. Also, focusing on the positive in life is a good way to ease stress.

“There is a body of literature about the healing effects of writing, so if a person is going through difficult times, journaling to know what they are experiencing can be a real outlet for them,” says Morales.

### **Educating on stress**

Patient education managers offering outreach education on stress might want to provide information on ways to get a good night’s sleep, developing an exercise regimen, or finding a sport to play, or finding ways to get involved in the local community. (For a list of helpful fact sheets on stress, see resource box at the end of the article.)

It’s also important for people to understand the signs and symptoms of stress and its impact on a person’s health. Symptoms might include: feeling angry, irritable or easily frustrated; feeling overwhelmed; change in eating habits; problems concentrating; feeling nervous or anxious; trouble sleeping; problems with memory; feeling burned out from work; feeling that difficulties in life cannot be overcome; and having trouble functioning in one’s job or personal life.

When stress is not dealt with, it may contribute to such physical problems as high blood pressure,

## **SOURCES**

For more information on providing outreach education on stress for Mental Health Month, contact:

- **Diana Morales**, MPH, Vice President of Public Education, Mental Health America, 2000 North Beauregard St., 6th Floor Alexandria, VA 22311. Telephone: (703) 837-4783.
- Find educational fact sheets on stress at [www.mentalhealthamerica.net](http://www.mentalhealthamerica.net). Fact sheets include: Coping with Stress Checklist; Stress: Coping with Everyday Problems; Managing Life’s Challenges; Building Social Support; Managing Life’s Pressures; Stress: Know the Signs.

heart disease and stroke, decreased immune defenses, cancer, stomach problems, and poorer brain functioning.

For those having difficulty dealing with stress on their own, it is always a good idea to seek professional counseling, says Morales. Help may come through pastoral counseling, discussions with a primary care physician or nurse practitioner, social worker, counselor, psychologist or psychiatrist.

“I think there are a number of places someone could go to get help and get to the path that is right for them,” says Morales. ■

## **Tips on clear writing strategies available online**

*Tips on style, simple language, and effective assessment*

Patient education managers spend a lot of time coordinating the writing and production of educational materials that are clear and easy to read. Many provide classes for health care professionals who wish to develop materials written for patients.

In this section, you will find a list of web sites that focus on effective communication, mainly in the written form. There are style guides, writing tips, and sites that provide lists of plain language suggestions for medical terms and more difficult words. These have been compiled for you to

## EXECUTIVE SUMMARY

Many PEMs spend a good portion of their job overseeing the production and purchase of written copy. To aid them in their work, several web sites are featured that explain the concept of clear writing and communication.

review.

Web sites:

- Beyond the Brochure: Alternative Approaches to Effective Health Communication: A Guidebook  
<http://www.cdc.gov/cancer/nbccedp/bccpdfs/amcbeyon.pdf>

The AMC Cancer Research Center, with collaboration and support from the Atlanta-based Centers for Disease Control and Prevention (CDC), Division of Cancer Prevention and Control, has developed "Beyond the Brochure" to assist health educators and health communicators in conceiving and producing educational materials and activities that do not rely solely on the printed word.

- Clear & Simple: Developing Effective Print Materials for Low-Literate Readers  
<http://www.nci.nih.gov/cancerinformation/clearandsimple>

This guide produced by the National Cancer Institute in Bethesda, MD, outlines a process for developing publications for people with limited-literacy skills. The process was derived from communications, health education, and literacy research and practice. In addition, writers who have produced low-literacy materials contributed their expertise.

- Developing Easy-to-Read Patient Education Materials  
[http://www.breasthealthga.org/Education\\_Program/health\\_literacy/KJFMLiteracy%20Slides.pdf](http://www.breasthealthga.org/Education_Program/health_literacy/KJFMLiteracy%20Slides.pdf)

This web site contains information from a slide presentation produced by Kara L. Jacobson and Felicia J. Morton of the Breast Health Connection of Georgia, which is a statewide coalition.

- Developing Patient/Family Education Print Material  
<http://www.cdha.nshealth.ca/patientinformation/developingPFEdMaterial.pdf>

Developing Patient/Family Education Print Material was created to provide guidelines and a process to follow in the development of patient/family education print materials. It was

produced by Capital Health, Halifax, Nova Scotia, Canada.

- Guidelines for Preparing Patient Education Handouts  
[http://www.ucdmc.ucdavis.edu/cne/health\\_education/guide.html](http://www.ucdmc.ucdavis.edu/cne/health_education/guide.html)

These guidelines were produced by the University of California, Davis, Center for Nursing Education. They were designed to help nurses and other health care professionals develop and evaluate patient education handouts.

- How to Create and Assess Print Materials  
<http://www.hsph.harvard.edu/healthliteracy/materials.html>

Tips from Rima E. Rudd from the Harvard School of Public Health: Health Literacy Website.

- Patient Education  
<http://www.u-write.com/>

Information from U-Write.com based in Mill Valley, CA. Tips on what makes an effective handout and hints on writing effective copy that include content, illustrations, design and production.

- Pfizer Principles of Clear Health Communication  
<http://www.pfizerhealthliteracy.com/pdf/PfizerPrinciples.pdf>

This is a handbook for creating patient education materials created by Pfizer, a pharmaceutical company. It was edited by Leonard G. Doak and Cecilia Conrath Doak.

- Scientific and Technical Information Simply Put  
<http://www.cdc.gov/od/oc/simpput.pdf>

Tips for creating easy-to-read print materials that were produced by the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry, both based in Atlanta.

- Teaching Patients with Low Literacy Skills  
<http://www.hsph.harvard.edu/healthliteracy/doak.html>

A book written by Leonard and Cecilia Doak that can be downloaded for free on the Harvard School of Public Health Web site. It is a classic resource on clear communication principles.

- The Health Literacy Style manual:  
<http://www.coveringkids.org/resources/docs/stylemanual.pdf>

This manual was prepared for Covering Kids & Families, a national program supported by the Robert Wood Johnson Foundation with direction provided by the Southern Institute on Children & Families. The manual includes information on

writing, formatting and style.

• The Plain Language Thesaurus for Health Communication

[http://www.nphic.org/files/editor/file/thesaurus\\_1007.pdf](http://www.nphic.org/files/editor/file/thesaurus_1007.pdf)

The Atlanta-based Center for Disease Control and Prevention's National Center for Health Marketing produced this thesaurus. It provides quick help on easy-to-understand word replacement. For example, replacements for the word "absorption" include "take in and soak up." ■

## Volunteers address low health literacy

*Provide someone to teach tasks*

**H**ealth care institutions may be able to borrow an idea from literacy volunteer organizations to improve health literacy among individuals who have low literacy skills and improve their ability to navigate the health care system.

In New Jersey, volunteers are taught to work with individuals, teaching them skills such as reading a thermometer, making a list of important emergency phone numbers, filling out health-related forms, reading medication labels and dosages, practicing dialogues for doctor's visits, and making an appointment.

The program is called "Just What the Doctor Ordered?" and was developed by **Elissa Director**, MA, executive director of Literacy Volunteers of New Jersey, based in Bridgewater.

In a two-hour training, volunteers learn about health literacy and its impact on the individual and the health care system. They are given real-life materials and instructional strategies they can use to teach health-related topics to adults with limited literacy and/or limited English skills.

The volunteers that work for literacy volunteer

organizations in the state of New Jersey initially receive 15 hours of intensive training before they are matched with a student, so they have some background, information, skills and techniques for working with low literate adults. The health literacy workshop is additional training.

During the workshop, the definition of health literacy is reviewed and the impact of low literacy on health is explored. Participants examine their role as a literacy tutor when introducing health literacy topics identifying the literacy skills needed to obtain, understand, evaluate, and use health information.

They then create some activities that enable adult literacy students to build their health literacy skills. Director also gives the workshop participants sample materials written at a low reading level on a variety of topics, such as a description of 911, how to use the emergency department, translations of difficult medical terminology, and samples of healthy lifestyles.

It is important to help people with low literacy learn to navigate the system a little more easily, because a person's literacy level is one of the strongest predictors of health, says Director.

People with low literacy are much more likely to have serious illnesses, they don't take advantage of preventive care, they have longer hospital stays, and they use the emergency department much more often as their primary source of care.

"There is a lot of research that has been done indicating the serious implications of low literacy and its impact on the individual and the health care system," says Director.

The literacy volunteer program is student-centered, so help is given in areas of need. For example, a student's child may have asthma, so volunteers will work to help him or her understand the pamphlets given by the physician. Volunteers also often teach students to fill out medical forms.

Director also created a two-hour workshop for health care professionals. During this workshop, she defines health literacy and discusses what general literacy skills are needed in order to navigate the health care system. These include reading, writing, math, critical thinking skills, communication skills, and the ability to use technology.

The workshop focuses on oral communication, and Director discusses ways to reduce barriers to communicating with low-literacy individuals, such as the use of the teach-back technique to see if patients comprehend what was said, as well as

### EXECUTIVE SUMMARY

Navigating the health care system is a learned skill and could be taught to patients with low literacy and/or limited English skills by trained volunteers.

## SOURCE

For more information on “Just What the Doctor Ordered?” contact:

• **Elissa Director**, MA, Executive Director, Literacy Volunteers of New Jersey, 120 Finderne Ave. #15, Bridgewater, NJ 08807. Telephone: (908) 203-4582. E-mail: director@lvnj.org.

covering only two to three main points when giving information.

Also discussed is the concept of plain language. For example, she tells physicians to explain terms such as cardiologist and avoid using such acronyms as EKG.

“I tell them I am going to teach them a new language, and the language they will leave with at the end of two hours is plain English,” says Director. ■

## DP and home care need improved 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.<sup>1</sup>

“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](http://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.

“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.

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.

"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 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.”

## Reference

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.<sup>1</sup>

One reason 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.<sup>2</sup>

Weekend discharges were particularly a problem because of short staffing, poor planning, and inadequate communication, the study found.<sup>2</sup>

And the third reason 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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1. Bowles KH, Ratcliff SJ, Holmes JH, et al. Post-acute referral decisions made by multidisciplinary experts compared to hospital clinicians and the patients' 12-week outcomes. *Medical Care*. 2008;46(20):158-166.

2. Bowles KH, Foust JB, Naylor MD. Hospital discharge referral decision making: a multidisciplinary perspective. *Applied Nursing Research*. 2003;16(3):134-143. ■

# 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 con-

vince 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.<sup>1</sup>

- **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.<sup>1</sup>

And all discharge instructions need to be explained and demonstrated whenever possible.<sup>1</sup>

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.

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"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

## CNE instructions/objectives

Nurses and other patient education professionals 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 activity each semester, you must complete the evaluation form provided and return it in the reply envelope provided in order to receive a credit letter. When your evaluation is received, a credit letter will be mailed to you.

After reading *Patient Education Management*, health professionals will be able to:

- **identify** management, clinical, educational, and financial issues relevant to patient education;
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- **develop** patient education programs based on existing programs from other facilities. ■

## COMING IN FUTURE MONTHS

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## CNE Questions

17. Details of the Re-Engineered Discharge Program (RED) include which of the following?
- A. Scheduling follow-up appointments.
  - B. Discuss test results.
  - C. Confirm medication plan.
  - D. All of the above.
18. It's important to teach people a way of living that makes it easier for them to handle stress as well as techniques for dealing with stress when it occurs.
- A. True
  - B. False
19. People unfamiliar with the health care system may need to know which of the following?
- A. How to make a doctor's appointment.
  - B. How to read a thermometer.
  - C. How to fill out a medical form.
  - D. All of the above.
20. Learning to reduce stress does not help prevent certain mental and physical health problems.
- A. True
  - B. False

**Answers: 17. D; 18. A; 19. D; 20. B.**

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

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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. ■