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ADVISOR

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IN THIS ISSUE

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Electronic health records are changing discharge planning in unexpected ways

Expect big push to expand IT reach

Special Report: Information technology changes DP

[Editor's note: In this issue of Discharge Planning Advisor, *there is a special report on health care information technology and how it is changing discharge planning, as well as transforming the entire health care system. In this issue, the cover story is about this transformation and its future. This issue also contains a story about how an Australian health system has used electronic discharge summaries as a building block. In the July issue, there will be additional stories about electronic health records and how IT leaders have handled the transition.]*

Information technology's toehold in U.S. hospitals and health care organizations likely will expand considerably in the coming decade as hospital systems and medical clinics receive federal stimulus package funds to make investments in electronic medical records (EMRs) and other new technology.

President Barack Obama signed the American Recovery and Reinvestment Act on Feb. 17, 2009, providing $1.5 billion to health centers for the acquisition of health information technology (IT) systems, as well as for other infrastructure improvements.

As hospital systems expand their use of IT, there will be some expected and unanticipated benefits to the discharge process, experts say.

"An electronic medical record allows us to create systems where we can integrate the bedside nurse, care coordinator, and discharge planner and give them all low barriers to access information and to break down silos between those groups," says **Russ Cucina**, MD, MS, an associate medical director of information technology and an assistant professor of hospital medicine at the University of California - San Francisco (UCSF) and UCSF Medical Center in San Francisco.

"That goes a long way to improving both the quality of discharge planning and the discharge process," Cucina says.

This change, which might occur fairly rapidly, also could result in some major growing pains as institutions rush into buying new technology without thoroughly assessing their system's capacity for absorbing it.

"I do think that as enthusiastic as I am to see the government providing

the stimulus funds, I have to say that I have concerns about both the completeness of the existing hospital information systems available for purchase and the preparedness of many hospitals to implement such a system," Cucina says.

"So, while it's wonderful we will see lots of money for purchases, I hope hospitals don't underestimate the challenges," he adds. "The money could be wasted if they do."

Another challenge will be to use the new IT in a way that everyone agrees will be very important to improving our nation's health care system and in building IT links between hospitals and other providers, experts say.

From a discharge planning perspective, it will be ideal to have an EMR that can send e-mails and medical information about patients to community physicians, pharmacies, and other providers.

But this level of integration may take years — perhaps decades — to be realized.

"Right now, the electronic records are used in about 4% of physician offices across the country," says **Donald Balfour**, MD, president and medical director of Sharp Rees-Stealy Medical Group in San Diego.

The chief obstacle is cost, but the stimulus package could overcome that one, he notes.

"Because of the cost, physicians are reluctant to use information technology," Balfour says. "The whole purpose of the stimulus package is to give money to physicians so they could make purchases themselves."

But then it's up to the hospitals and physicians to connect their electronic networks. This also is an expensive and time-consuming task that might only be possible to accomplish if hospitals are permitted to help smaller physician practices with the transition to the electronic age, Balfour explains.

"We've been trying to loosen the [inducement] laws so hospitals can help physicians by putting a computer in their offices," Balfour says. "But right now that's considered inducement."

Hospitals are further along in implementing information technology, although it's the rare hospital that has a completely electronic medical record system.

The American Society of Health-System Pharmacists (ASHP) published results in December 2008, of a national survey on informatics in hospitals. The survey found that 42.9% of hospitals had one or more parts of a medical record in electronic form, but that only 5.9% of all hospitals had a complete EMR system.[1]

"Overall, even smaller hospitals are implementing forms of technology," says **Karl F. Gumpper**, BSPharm, BCNSP, BCPS, FASHP, a co-author of the ASHP survey study and director of the section of ASHP's pharmacy informatics and technology.

"When you look at the different choices and

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different programs for implementing [EMR], a lot of it depends on the size of the hospital, what its structures are like, and whether it's a for-profit or not-for-profit hospital," Gumpper says.

The ASHP informatics survey also found that of the hospitals that used some part of an EMR, only 53.2% allowed all health care providers in the hospital to have access to the electronic records.[1]

Nurses, pharmacists, and physicians were routinely given access, but mid-level practitioners were not granted access at a number of hospitals.[1]

U.S. hospitals might learn how to achieve success in transitioning to EMRs by studying the way IT transitions were handled in other countries.

For instance, primary care physicians in the United Kingdom have been using EMRs since the late '80s, says **Richard Tanner**, MD, a professor of medicine at the University of Pennsylvania School of Medicine in Philadelphia. Tanner has published studies that used the UK electronic medical record database.

"You'd have thought it was the National Health Service who forced them to do it, but that wasn't the case," Tanner says. "They started using EMRs on their own, because they found it was more efficient for them to use EMRs, so it was a provider-generated phenomenon."

As physicians transitioned to IT, a consensus began to develop around the idea of creating a national database that could be used for research purposes, as well as for more effective care transitions, he adds.

The National Health System requires that all medical providers report patient data directly to the primary care doctor, so the health record captures all major health events that occur in the patient's life, Tanner says.

Australia is another country where EMRs are more widely used by medical providers.

In Australia, general practitioners are the leaders in moving the industry to information technology, says **Melanie Jane Alderton**, Bapp Sci Hons, health information manager of medical records for Balmain Hospital in Balmain, New South Wales, Australia.

Hospitals are moving more slowly in adapting IT links to other providers, mostly because of data security and privacy issues, Alderton notes. **(See Q&A about Australia's electronic discharge summaries, p. 28.)**

One obstacle to global EMRs that health care IT leaders have been addressing in the United States involves standardization of terminology.

There is a variety of health IT vendors in the United States, and each health provider might adopt and adapt IT to fit its own culture. So even within a health system, there will be one type of IT for the pharmacy department and another for physicians and another for radiology, etc.

But for these various electronic systems to communicate with one another, there need to be standard definitions, says **Jane Brokel**, PhD, RN, an assistant professor at the University of Iowa's College of Nursing in Iowa City, IA. Brokel co-authored a recent study about how a large Catholic health care system redesigned its care processes using an electronic health record.

"We utilized a lot of the standardized nomenclatures that have been adopted to meet the Health Information Technologies Standards Panel (HITSP) federally," Brokel says.

HITSP is funded by the U.S. Department of

Health and Human Services (HHS) and is sponsored by the American National Standards Institute (ANSI). Its purpose is to develop a set of standards that will enable and support interoperability among health care software applications as they interact in a national health information network.

"Adoption of standardized nomenclatures and terminologies has to be agreed upon," Brokel says. "Free texting is not easily exchanged with the health information exchange infrastructure being put in place." ■

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Special Report:
Information technology changes DP

Australian system relies on e-discharge summary

Physicians prefer electronic discharge summary

[***Melanie Jane Alderton**, Bapp Sci Hons, health information manager of medical records for Balmain Hospital in Balmain, New South Wales, Australia, has researched the use of electronic discharge summaries in Australia.* Discharge Planning Advisor *asked her in this Q&A story about her research and about how information technology impacted discharge planning in her country.]*

DPA: In your research you've concluded that a majority of general practitioners prefer the electronic discharge summary. What are some of the reasons for this preference?[1]

Alderton: The main reason is legibility. Doctors' handwriting has commonly been illegible. The electronic discharge summary (eDRS) has more complete information. The fields in the form act as a prompt for the clinician to fill in, such as Pdx, Adx, history, summary of treatment, and follow-up information. In addition, the discharge medications and recent diagnostic tests are also automatically populated into the document.

DPA: In the United States, hospitals are slowly moving toward electronic medical records, including discharge summaries. We still have a long ways to go. How far along are Australian hospitals with regard to electronic medical records and integration of the discharge process?

Alderton: First, the discharge summary is really one of the foundation building blocks to the medical record, as this is the key document used for ongoing patient care, continuity of care, and communication between all other health care providers.

General practitioners in Australia are more advanced than tertiary institutions in the transmitting and access of electronic health information. They are more than ready to receive discharge summaries electronically, but we are progressing rather slowly in making it available to them electronically. This mostly has to do with data security and privacy issues. Our Area Health Service has just commenced on a pilot project working with general practitioners who elect to "opt in" to receive discharge summaries electronically.

Nationally, we are slowly progressing towards the goal of an electronic health record. The main problem, as I am sure you would be familiar with, is the many disparate clinical information systems. New South Wales is probably leading the way, and, in fact, our specific area Health Service is leading the way in New South Wales.

The New South Wales government has regulated that organizations may only purchase one of two [IT products] — PAS - Cerner (US) or iPMS (UK), and this has helped with amalgamation.

We have a hybrid record — part paper and part electronic. Within area health services, the electronic information can readily be shared between different hospitals. A web site that gives information of what is happening nationally is located at http://www.nehta.gov.au/.

DPA: Please tell us a little more about your findings.

Alderton: There's not much more to say other than what was published. I was only evaluating the quality of information between the manual and electronic discharge summary. The eDRS scored higher on completeness, although there were slightly higher medication errors due to transcription. Also, doctors — the general practitioners — felt that the information in the discharge summary for follow-up could be improved on.

DPA: As hospitals switch to electronic documentation and records, what would be your advice on how best to handle this transformation?

Alderton: There really needs to be a compre-

hensive change management strategy with pre- and post-evaluation of the various components. Most importantly, all affected staff need to be kept updated with the progress and made to feel they are part of the process, as well as being given adequate training. This is probably the biggest key to a successful implementation.

My other suggestions are:

- Ensure staff feel part of the process and there are feedback mechanisms in place.
- Champions should be identified in each area to assist with the change management.
- The implementation should be piloted and evaluated first in a smaller area. Do not go live until there has been extensive testing and trialing.
- Develop a comprehensive back-up strategy — paper and manual — that can be implemented in times of system failure so that there is no risk of compromised care to patients.
- Ensure there are clear links between paper-based and electronic information so that users of the information have a complete record.
- Have a comprehensive and systematic training program whereby users are only given access to the system when they have completed training.

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Hospital discharge process can be more efficient

Nursing satisfaction rises, turnover drops

While hospital discharge planners make certain each patient's discharge and transition in care are handled with quality of care and safety in mind, it's the job of hospital operations chiefs to make certain the entire process runs smoothly and efficiently.

A poorly run discharge process might result in high nursing dissatisfaction and turnover, bed census swings between high vacancies and overcrowding, and wasteful resource spending.

For instance, when nurses feel their staff-to-patient ratio is too high, they are unhappy and will not stay long at their jobs, says **Michael Bundy**, MBA, vice president of operations support at Wellmont Health System in Kingsport, TN.

At another Tennessee hospital, Bundy had overseen a discharge process restructuring that resulted in a major change in nursing turnover rates.

"We went from 100 vacancies and 70 contract nurses to 12 vacancies and no contract labor," Bundy says. "We were saving hundreds of thousands of dollars."

The 544-bed hospital also saw a decrease in its length of stay (LOS) from an average of 5.2 days with a case mix acuity level of 1.6 to an average LOS of 4.4 days with a case mix acuity level of 1.7, Bundy says.

"So, the hospital had a higher acuity level with a shorter length of stay and still maintained all beds full," he adds.

The hospital's volume has remained high, above 90% of beds occupied, despite the economy having impacted demand through surgery postponements, Bundy notes.

"We are seeing a decline in volume, but we're still above 90%," he says.

Before making changes in discharge operations, the hospital's discharge process was caught in a cycle of inefficiency; the hospital had too many patients waiting for inpatient beds, so the nurse-to-patient ratio was kept high. The high ratio led to nursing dissatisfaction, high turnover, and workflow problems.

For instance, nurses would keep well patients in beds because these patients didn't take as much work and would ease the pressure caused by high nurse-patient ratios.

"Or the nurses would discharge patients in the evening, so they didn't have to do another admission on their shift," Bundy says. "So, they're holding those patients in bed, but I have to manage the whole hospital, and the emergency room is backing up."

Since there was a strong demand for more beds, nurses were given more patients, which led to their feeling overwhelmed, and the cycle continued.

The solution was to reach an agreement with nurses, Bundy notes.

Bundy agreed not to give them a higher ratio of patients than the nurses thought would impact quality of care. But in exchange, the nurses would make all of their discharges early in the afternoon, so that when the emergency department began needing beds, there would be enough available.

"So now we've reduced risk, and it's much

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less stressful," Bundy says. "It worked extremely well, and we kept the ratio down."

This was the chief reason the nursing turnover rate dropped dramatically, and it's led to other positive outcomes, he says. **(See story on how hospital improved discharge process, p. 31.)**

A better discharge process also improves patient safety, Bundy says.

"Timely discharges are the answer to patient safety," he says. "The longer a patient is in the hospital, the more likely there will be a medical error or a nosocomial infection or fall."

Patients and physicians respond to the improved process by frequenting the hospitals that handle patient flow better.

"When you improve the discharge process, customer service goes up, and then the demand for the beds goes up, so you've created new demand," Bundy explains.

While this can put more pressure on a hospital and its discharge process, it's a better pressure since the revised discharge process eliminates waste.

"You get all of the wasted days out and continually improve the cycle and remove barriers that prevent nursing staff from getting patients out," Bundy says.

Creating a more efficient discharge process begins with understanding what drives the hospital's bed demand, Bundy notes.

For instance, in the hospital that is emergency department (ED)-driven, it might make sense to have an early afternoon discharge time, because the emergency department starts to pick up patients who need inpatient beds in the afternoon, he explains.

But if a hospital picks up more inpatients from surgeries and is a surgical suite-driven facility, then the discharge timeline is very different. The hospital might then need to make certain beds are available by 11 a.m., Bundy says.

And even this varies according to which types of surgeries are most commonly performed.

"You need to know the bed demand down to the type of procedure that day," Bundy says. "You could need beds at 9 a.m., or for some surgeries, you might not need beds until noon."

It's also essential to collect data, develop metrics, and hold people accountable for inefficiency and discharge bottlenecks.

One important metric is the time the patient is admitted, measured from when the physician wrote the order to the time the patient is accepted on the floor, Bundy says.

"That's the holy grail of the discharge process," he says.

So each month someone should be analyzing demand for beds by assessing the average time patients are admitted and how many minutes lapsed before the patient was in a hospital bed, he adds.

"You have to make sure you have beds available, and you have to make sure the discharge process works," Bundy says.

For example, these are some metrics that could be measured:

- What is the average discharge time?
- What percentage of patients need a bed at 11 a.m.?
- What percentage of patients can be transferred to a bed at 11 a.m.?
- How long are admitted patients being held in the emergency department?
- How long are post-surgery patients being held in the post-anesthesia care (PAC) unit?
- How many times were surgeries postponed because the PAC unit was full?
- Where is there the greatest demand for resources?
- How well is the hospital meeting the resource demand?
- How many transfers could the hospital accept in a month?
- What is the turnaround time for X-rays?

"You put everything on an Excel spreadsheet, so it doesn't take anyone with special training to see the numbers day by day," Bundy says.

Even when a hospital makes these discharge process changes, it will continue to be necessary to make adjustments and improvements, he says.

"In tertiary care, the discharge process is never complete," Bundy says. "You can always find inefficiency." ■

Expert offers tips on improving DP flow

Knowing bed needs is crucial

Hospitals can save hundreds of thousands of dollars, improve bed occupancy rates, and reduce staffing discontent by improving discharge operations and patient flow, an expert suggests.

The key is to know what kind of patient bed needs the hospital has and planning discharge and throughput to meet these needs resourcefully.

"The discharge process at one hospital isn't the same as it is at another hospital because each hospital's needs are different," says **Michael Bundy**, MBA, vice president of operations support at Wellmont Health System in Kingsport, TN.

"That's where we've missed out as an industry," Bundy adds. "We pick obligatory times in a day and send people out the door."

But hospital discharge timing should be determined by whether a hospital is surgery-driven, emergency room-driven, etc., he says.

"You need to analyze where the demand for inpatient services in-house are and then set a realistic target," Bundy says. "Figure out what the discharge targets are by unit and tailor your discharge planning."

Bundy offers these suggestions for how hospitals can improve their discharge planning operations:

*** Pre-screen patients for discharge:** Hospitals should have nurses or discharge planners pre-screen patients, even in the evenings, to find patients who are good candidates for discharging the next morning, Bundy suggests.

"You could call the doctor at 6 a.m. to say, 'We think he's a good candidate for discharge, and we need someone to write an order,'" he adds.

If the physician agrees, then someone needs to keep track of when the physician wrote the discharge order and when the patient left the hospital.

If there's a delay, the tracking metrics should show where the process failed and how it might be fixed, Bundy says.

*** Train nurses to look for discharge barriers:** Patients could be grouped into three categories, Bundy suggests. These include the following:

- Patients who will be discharged that day;
- Patients who probably could go home that day, but some obstacles need to be handled first;
- Patients who could not be discharged that day.

The key to improving discharge flow is to make certain the patients who are ready to be discharged are discharged and to remove the obstacles to discharging the second group.

This means nurses have to be trained to think about what needs to be done with patients today so that tomorrow some of them might be discharged.

"The nurse needs to say, 'This patient is not on PO pain medications, so I have to get the patient on PO pain medications during my shift so this is not a barrier to the patient being discharged tomorrow,'" Bundy explains.

Or a nurse will need to make certain the outstanding physical therapy (PT) order for a patient in group two is handled on a priority basis so that PT visit isn't an obstacle to the patient being discharged the next day, he adds.

Nurses need to review the groups of patients, looking at all of the multidisciplinary tasks that need to occur across the spectrum of care. Then they should take care of those up front, Bundy says.

"You tell the night nurse, 'This is your assignment: you're screening that patient for a discharge bucket,'" he says. "Then in the morning, part of the nurse's report is the discharge category the patient is in."

The key is to train nurses to think this way, Bundy adds.

*** Use case managers for disposition of patients:** Case managers become disposition managers who help nurses with discharging patients.

"The nurse manager ultimately is responsible for discharging patients on her floor, so the case manager does the same job in the discharge process that I did as an operations officer," Bundy says. "The case manager removes barriers to discharge."

For instance, the case manager will find a nursing home placement for a patient and start planning this when the patient is in the second category, he adds.

"This changes the function of case management and makes case managers more produc-

tive," Bundy says. "Before, case managers would be on a mission of trying to find which patients need their help."

*** Stay on top of staff training:** A medical-surgical director worked well with nurses and physicians as the discharge process changes were explained, Bundy says.

"She was a driver of the process and would show up at 6 a.m. to listen to a report and make sure patients were identified and outside barriers were honed into the support structure," Bundy explains. "She worked wonderfully with the night nurses to help them understand."

Initially, there was a large, multidisciplinary team involved. But this quickly evolved into a blame game, rather than serving as the necessary catalyst for physicians, nurses, and case managers to work together, he says.

The key to success was to have one director be the point person for educating staff on the changes and to collect metrics so people could be held accountable for their own roles in late discharges, Bundy says.

Also, Bundy spoke with nurses, answering their concerns.

When Bundy was forced to give nurses extra patients at night, he'd have a discussion with them and say: "I'll never break your nurse-to- patient ratio if you discharge by this time," he says. "If you're willing to begin discharging patients at 11 a.m. and give me three rooms in your assignment, then I'll have them flipped around by 3 p.m., and your personal ratio will be one to three, growing to one to six."

Then Bundy would speak with physicians, starting with those who had the most complaints about patients being stuck in the operating room suite for excessive hours.

"We'd go to each service line and go through the cool diagram that shows how the operating room hits the post-anesthesia care (PAC) unit and how everything hits the inpatient floor," he says.

"We'd show physicians their personal discharge times and demonstrate what capacity we could have created from their own individual waste of time," Bundy says. "They'd say, 'My one or two beds couldn't tie up the whole 500 bed system,' so I'd have to show them that we were at capacity every day, and one patient did make a difference."

Through these conversations, Bundy and hospital leadership obtained buy-in from nurses and physicians. ■

Scale measures quality of hospital discharge process

Brief questionnaire is valid

Researchers have developed various tools to give discharge planners and physicians objective ways to determine whether patients are ready to be discharged from the hospital to home.

One new tool, called B-PREPARED scale, provides a brief, but thorough system of measuring a patient's readiness.

The new tool is based on a scale developed by Karen Grimmer-Somers, PhD, associate professor, Centre for Allied Health Research, University of South Australia, North Tce, Adelaide, Australia.[1]

The B-PREPARED scale was administered one week after discharge and can be used to evaluate a hospital's discharge interventions and for quality improvement efforts.

"Dr. Grimmer and her group had done focus groups to get down the qualities that would measure what we value," says **James F. Graumlich**, MD, FACP, associate professor of medicine and clinical pharmacology and interim chair in the department of medicine at the University of Illinois College of Medicine in Peoria, IL.

"But the scoring system wasn't optimal for what we wanted to use in our particular research," Graumlich notes. "If there was no response, it would give a missing response score, and that turns out to be problematic when doing statistics, so we changed the scoring response system."

For example, in the original scoring system, if a person was asked whether he or she received information about medication side effects and had no response because he or she wasn't sent home with any medication, then the person would be missing points on that question, Graumlich explains.

"In our system, that person would be considered satisfied and would get the highest score," he adds.[2,3]

When Graumlich and co-investigators validated their new scoring system in the study patient cohort, they found that the new scoring system discriminated very well between patients who did well after discharge and those who did not do well and returned for emergency department (ED) visits.

"It also correlated with whether patients were

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satisfied with the information they received about medications," Graumlich says.

The recent study also showed that the Australian questionnaire, which was developed for patients over 65 years, was valid for people who are at high risk and younger than 65 years, Graumlich says.

"Certain people who are younger have a lot of readmissions for diseases like HIV infection, sickle disease, multiple sclerosis, and others, and we didn't want to exclude those people," he explains.

The 11-item B-PREPARED scale includes such questions as "Before you were discharged from hospital, was there any other information you would have liked while you were in the hospital to prepare you for coping at home?"[2]

There are at least 15 frequently used standard assessment tools available for nurses, therapists, and social workers, including the Functional Independence Measure (FIM), the Mini Mental Scale, the Elderly Mobility Scale (EMS), and others.[1]

And there are survey instruments designed specifically for hospital discharge, including the Readiness for Hospital Discharge Scale and Care Transitions Measures, Graumlich notes.

One advantage of the B-PREPARED tool is that it is among the shorter questionnaires, he says.

"The more questions you have, the less practical it becomes to administer to people and to get them to answer all the questions," Graumlich says. "One of the choices we made in our design was to make the scale practical to see if we could get meaningful information out of a shorter questionnaire."

Hospitals that discover a problem with their discharge process through their more general patient satisfaction surveys might want to use the B-PREPARED instrument to pinpoint what those problems are, he suggests.

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DPs need to communicate with families about APS

Study finds APS used as "safety net"

Challenging times economically mean discharge planners might have fewer referral options than they've had in the past. This gap could lead discharge planners to find solutions that create other problems.

For instance, hospital discharge planners sometimes rely on adult protective services (APS) as a safety net for problematic cases at discharge when better family communication would be more appropriate, research shows.[1]

DPs sometimes call APS when there's evidence of abuse. But they'll also call APS when they're concerned about safety. For example, there might be a case where the patient needs either home care services or to be transferred to a nursing facility, but the patient and family, who often do not have health care coverage for home care services, insist they can handle everything on their own.

"Part of what happens is when there's any programming change for how hospitals or nursing homes or home health agencies are reimbursed for care, those policies inadvertently influence who you choose to take for a resident in your nursing home or for a client in your home care agency," says **Lori L. Popejoy**, PhD, APRN, GNS-BC, an assistant professor at the University of Missouri School of Nursing in Columbia, MO.

So, the discharge planner's options for referral are limited, especially if the patient doesn't want to pay for out-of-pocket support services.

And the DP is worried about sending the patient home without any additional support. Since the state pays for visits and services pro-

SOURCES

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vided through the adult protective services office, the DP will call APS about the patient, Popejoy says.

"They hope APS will be able to convince the family to take additional services," Popejoy explains.

Plus, by calling APS, the discharge planner feels as though she at least did something to help the patient. But this approach isn't optimal, Popejoy says.

"APS should be there and really used in places where adults need protection," Popejoy says. "But because of dramatic service cuts to Medicaid in our state [Missouri], they're calling adult protective services to get services to people."

The problem is that DPs in Popejoy's study were not communicating their plans to patients and families, and this raised ethical concerns, Popejoy says.

"Discharge planners were inclined to call adult protective services to say, 'This person is going home, and we're very concerned about him,' but there was a tendency to not tell the older adult that they had been hot-lined to adult protective services," Popejoy explains. "That's a little bit of an ethical problem."

The patients in these cases were older, frail adults who are returning home with older, frail spouses. And there is concern that they might not be able to handle the medication and other health care issues, she adds.

Discharge planners would recommend a discharge plan that helps the patient, but the patient and family might decline.

"You can encourage them and tell them about services available to them, but you can't force them to do something they don't want to do," Popejoy says.

The ethical dilemma is when DPs call APS

CNE *questions*

9. The American Society of Health-System Pharmacists (ASHP) published results in December 2008, of a national survey on informatics in hospitals, finding that what percentage of hospitals has one or more components of an electronic medical record?
A. 26.4%
B. 39.1%
C. 42.9%
D. 52.2%

10. Which of the following metrics could a hospital measure in an effort to improve the discharge planning process?
A. What percentage of patients needs a bed at 11 a.m.?
B. How long are admitted patients being held in the emergency department?
C. How long are post-surgery patients being held in the post-anesthesia care (PAC)
D. All of the above

11. Which of the following is the wrong reason for discharge planners to refer patients to adult protective services, according to Lori L. Popejoy?
A. For a safety net
B. When they see bruising on patient
C. When they suspect emotional abuse of patient
D. None of the above

12. Which of the following is <u>not</u> a predictor of a patient having a positive outcome upon discharge?
A. Patient having a positive attitude
B. Patient having self-care ability
C. Patient being female
D. Patient being younger and independent

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

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with **this 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. ■

to say that they have an older patient who is returning to a potentially unsafe home environment, but they do not tell the patient and family that they've done so, she adds.

"My concern is that when health care teams don't tell them they'll call APS, then they're potentially missing a really good opportunity to talk with the patient about it," Popejoy says. "They could tell the patient, 'I'm very concerned about your going home; I don't think you'll be safe, so I'm going to call adult protective services to tell them I'm concerned about your going home.'"

Another approach would be for DPs to hold a patient/family meeting and explain the exact nature of the health care team's concerns, Popejoy suggests.

The DP could explain why the health care team is concerned and discuss the issues the patient and family are facing, she adds.

"Have a forthright conversation with them, asking them, 'How do we get you to the next level of going home?'" Popejoy says.

"I honestly think that calling APS is not completely realistic, but if we're taking that approach, we need to be clear with patients and families, because you could fracture your trust with the patient," she adds.

"Tell them that you have concerns, and you feel they need more services than you're able to give them, so here's a phone call you can make," Popejoy says. "Tell them that a case worker from APS will call them to talk further and you really hope they'll take the time to talk with them and hear what they have to say."

Reference:

1. Popejoy LL. Adult protective services use for older adults at the time of hospital discharge. *J Nurs Scholarsh*. 2008;40(4):326-332. ■

Researchers study transition to community successes

Study offers predictors

Researchers who reviewed thousands of studies have found that enhanced hospital discharge support might prevent or delay hospital readmissions for heart failure and stroke patients.[1]

Other predictors of a positive outcome upon discharge include patients having a positive attitude, family support, self-care ability, self-confidence, and being younger and independent, says **Lolita Jacob**, DNP, a family nurse practitioner at Monmouth Medical Center in Long Branch, NJ. Jacob co-authored the study.

"If patients have confidence in themselves and can do self-care, then they are the kind of people who have a successful transition to the community," Jacob says. "Those who have a negative perception toward the future and life and who might go home and say they cannot do this at the outset, then those are the kind of patients who will have

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

- Interdisciplinary collaboration model helps with timely discharge
- Improve discharge process during short stays
- Teach staff safe transitions in care
- DPs make use of hospital's electronic sign-out system
- Health system's IT initiative leads to 25% reduction in mortality

SOURCE

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problems during their transition and are most likely to be readmitted or to have unscheduled emergency visits."

Some of the studies Jacob reviewed found that patients with a heart failure diagnosis could have a more successful transition to community care if they were given discharge preparation and support.[1]

The research also showed that increased age, length of hospital stay, and Medicaid enrollment were among the risk factors for a poor transition among stroke patients.[1]

The research has implications for discharge planners, suggesting that they might predict whether a patient will transition to the community successfully based on the patient's attitude.

For example, patients who talk cheerfully about the discharge while still in a hospital bed and are eager to return to work or to their families might be the ones who have the most successful transitions to community, Jacob says.

"Some people are not so eager to go home because of poor family support or a lack of confidence in their ability to care for themselves," Jacob explains.

For some of these patients, the discharge planner or case manager might have to help the patient find additional community support, or else the patient soon will be rehospitalized.

"But there also are patients you cannot satisfy," Jacob says.

"I see those kinds of people," she adds. "They want to be coached every time, or they live with a family member who doesn't understand their illness and who doesn't give them support."

When case managers see patients with this mindset, then it might be best to keep the patient hospitalized a little longer until arrangements can be made to send them to a skilled nursing facility where they might have more time to improve physically and in self-confidence before they are sent home, Jacob suggests.

In other cases, it might be the family members who present the obstacle to a successful transition to community care.

For instance, Jacob has had a case where the patient is disabled, uninsured, and in need of palliative care because there is no real possibility of recovery.

"Every time the patient is moved to the skilled nursing facility, the family member complains that the nursing facility didn't give the patient the right medication," she adds.

Reference:

1. Jacob L, Poletick EB. Systematic review: predictors of successful transition to community-based care for adults with chronic care needs. *Case Man J*. 2008;9(4):154-165. ■

DISCHARGE PLANNING
ADVISOR

DPA060109TM

PLEASE NOTE: If your correct name and address do not appear below, please complete the section at right.

Please make label address corrections here or PRINT address information to receive a certificate.

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CNE Evaluation: Please take a moment to answer the following questions to let us know your thoughts on the CNE program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your certificate.**

CORRECT ● **INCORRECT** ⊘ ✓ ✗ ⚠

1. If you are claiming nursing contact hours, please indicate your highest credential: ○ RN ○ NP ○ Other _____

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
After participating in this program, I am able to:						
2. Identify particular clinical issues affecting discharge planning.	○	○	○	○	○	○
3. Apply discharge planning regulations to the process of discharge planning.	○	○	○	○	○	○
4. Describe how the discharge planning process affects patients and all providers along the continuum of care.	○	○	○	○	○	○
5. Cite practical solutions associated with the discharge planning process based on independent recommendations from clinicians working in the field or from specific regulatory bodies.	○	○	○	○	○	○
6. The test questions were clear and appropriate.	○	○	○	○	○	○
7. I detected no commercial bias in this activity.	○	○	○	○	○	○
8. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
9. This activity has changed my clinical practice.	○	○	○	○	○	○

If so, how? _____

10. How many minutes do you estimate it took you to complete this entire semester (3 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers to the correct ones listed. _____ minutes.

11. Do you have any general comments about the effectiveness of this CE program?

_____

I have completed the requirements for this activity.

Name (printed) _____ **Signature**_____

Nursing license number ***(required for nurses licensed by the state of California)*** _____