DISCHARGE PLANNING
ADVISOR

AHC Media LLC

## IN THIS ISSUE

■ Research projects show how to improve the discharge process. . . . . 64

■ Research shows decrease in care continuity among older adults . . . . . 65

■ Uninsured, undocumented patients present complicated challenges at discharge . . . 67

■ Children's hospital discharges are always complicated . . . . . 69

■ Discharge checklist is simple, effective tool. . . . . 70

■ Here's a look at discharge checklist tool . . . . . 72

■ **Inserted in this issue:**
— *2009 Index*
— *CNE Evaluation*
— *Swine Flu Insert*

**Financial Disclosure:**
Editor Melinda G. Young, Managing Editor Karen Young, and Associate Publisher Russ Underwood report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor/Nurse Planner Toni Cesta discloses that she is principal of Case Management Concepts LLC.

NOVEMBER/
DECEMBER 2009
VOL. 1, NO. 6 • (pages 61-72)

# Improving hospital discharge process is project tackled through variety of plans

*After-hospital care plan is one method*

National agencies have committed millions in federal funding to studies of how to improve the hospital discharge process, and as study results come in, certain best practices are emerging.

Also, there is growing evidence that the transition from hospital to home should be a priority target for improvement in the nation's health care policies, both to reduce unnecessary health care costs and to improve care quality for patients.

One recent study in *The New England Journal of Medicine* showed that nearly one-fifth of the more than 11 million Medicare beneficiaries who had been discharged from a hospital were rehospitalized within 30 days. More than one-third were rehospitalized within 90 days.[1]

Even more striking, the study showed that 67.1% of patients who were discharged with medical conditions were rehospitalized or died within the first year after discharge.[1]

"The transition from hospital to home is an extraordinarily high-risk time for patients and their families," says **Jeff Critchfield**, MD, an associate professor of medicine in the department of medicine at the University of California — San Francisco. Critchfield also is chief of the division of hospital medicine at San Francisco General Hospital.

Patients often are transferred from an area of intense acute care surrounded by doctors, nurses, nutritionists, and other providers to their homes, where support and follow-up are minimal, he explains.

"We're realizing there are several areas of significant challenges for patients being discharged home, and one of these involves their medications," Critchfield adds. "There is a lot of confusion around people taking their meds, understanding their meds, having enough money for meds."

Another problem area involves getting patients to primary care visits after they are discharged from the hospital, Critchfield says. **(See story about ways to improve the discharge process, p. 64.)**

The *NEJM* study also found that 50.1% of patients who were rehospitalized within 30 days after discharge had not seen a community physician after their initial hospitalization and discharge.[1]

With all the confusion the hospital discharge process and medication changes can cause patients, it is important for a primary care provider to

see them and assist them with follow-up care, Critchfield says.

"The data we're learning about discharges and transitions are an example of what I think is true: our care is not patient-centered care," he adds. "The hospital discharge is an intensely vulnerable time, and we as a society haven't put anything in place for that."

**Discharge Planning Advisor** (ISSN# 1940-8706) is published every other month by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304.

**POSTMASTER**: Send address changes to ***Discharge Planning Advisor***, P.O. Box 740059, Atlanta, GA 30374.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 7 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 7 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 7 clock hours.

This program was approved by the National Association of Social Workers (provider # 886399925) for 7 continuing education contact hours.

This activity is valid 36 months from the date of publication.

The target audience for **Discharge Planning Advisor** is social workers, case managers, and nurses.



**Subscriber Information**

**Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST. World Wide Web: www.ahcmedia.com. E-mail: customerservice@ahcmedia.com.**

**Subscription rates:** U.S.A., one year (6 issues), $199 Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $78 each. (GST registration number R128870672.)



Editor: **Melinda G. Young**, (846) 241-4449.
Associate Publisher: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).
Managing Editor: **Karen Young**, (404) 262-5423, (karen.young@ahcmedia.com).
Production Editor: **Ami Sutaria**.




**Editorial Questions**

For questions or comments, e-mail **Melinda G. Young** at melindagyoung@charter.net.

However, a number of physician researchers have worked in the past decade on models for improving the discharge process.

For example, the reengineered hospital discharge program (Project RED) showed in a recent study that a number of discharge services can reduce hospital utilization by 30% within 30 days of discharge.[2]

Project RED received more than $7.5 million in funding from the Agency for Healthcare Research and Quality (AHRQ) and the National Heart, Lung and Blood Institute of the National Institutes of Health (NIH).

"We have now designed the reengineered discharge, and that had never happened before," says **Brian Jack**, MD, an associate professor and vice chair of the department of family medicine at Boston University School of Medicine and Boston Medical Center in Boston.

"We're looking at how to implement and disseminate this improvement, whether through hiring additional personnel or through staff already in hospitals," Jack adds. "This is where we are now in terms of hospitals deciding what's possible."

Jack and co-investigators have been working on the reengineering discharge project for most of the past decade. Jack's involvement stemmed from a personal interest in improving patients' experiences during care transitions.

"While working in the hospital, I noticed how we were sending people home who were not adequately prepared to take care of themselves once they got home," Jack says. "Once they left the hospital, the chances of their returning back to the hospital was much greater, and it was clear to me that we could do a whole lot better than that."

He clearly remembers one case in particular: "I was in a patient's room once without my white coat on, and I was just sitting in a chair beside an elderly man who was there to have his pacemaker adjusted," Jack recalls. "He was on Coumadin (warfarin), and he had been instructed to stop the blood thinner for a couple of days to have his pacemaker adjusted."

The patient was told to go back on warfarin when he returned home. But right before he was set to leave the hospital and as his elderly wife was warming up the car, the hospital medical team decided to give him a prescription for a three or four-day bridge dose of injectable blood thinner to help the warfarin build up again, Jack explains.

"The nurse walked in just as he was leaving and said, 'I don't have time to teach you how to

do this, so take this,' and she handed him a cellophane-wrapped box," Jack says.

She had handed him a DVD with instructions for injecting himself with the drug, and it was clear to Jack that the man was bewildered and would not be able to handle this on his own, even if he had a DVD player, which the nurse had never inquired about.

"The nurse could have said, 'I'm going to take 15 minutes and show you how to do this,' and then she could have had him practice on an orange or something," Jack says.

There are many discharge cases like this, and that's why Jack and other physicians and researchers have been working on reengineering the discharge process.

For example, another project is the STAAR program (State Action on Avoidable Rehospitalizations), which is a four-year initiative, sponsored by the Institute for Health care Improvement (IHI), says **Elizabeth C. Gundersen**, MD, an associate chief of hospital medicine for UMass Memorial Medical Center in Worcester, MA. Gundersen also is the physician quality officer at UMass.

Hospitals in Massachusetts, Michigan, and Washington state are involved in STAAR, which has a goal to reduce readmission rates by 30%.

"Our goal is to reduce readmissions on a statewide basis and increase patient satisfaction scores with regard to discharge planning," Gundersen says.

STAAR has just begun, and UMass has formed a steering committee of hospital leaders among physicians, nurses, case managers, as well as health providers in the community, she explains.

"We want everyone to work together as a team, including not just those sending patients out of the hospital, but those receiving patients in the community," Gundersen says.

The project will identify hospital needs starting with the day of admission and focus on effective teaching, including use of the teachback method, she adds.

"Also, there will be more emphasis on scheduling appointments with patients to increase compliance," Gundersen says.

Too often, hospitals leave it to chance that patients will follow up on instructions to visit their primary care physician (PCP) or take their medications according to instructions or that the PCP will understand all that happened in the hospital, she notes.

"Our care needs to be more patient-centered, and the process of discharge or transition out of the hospital needs to happen earlier in the hospitalization," Gundersen says. "One thing that frustrates families most is on the morning of discharge being told that they are going home that day at 1 p.m."

This is an anxiety-provoking situation for patients and their families.

"We sometimes do health care in a vacuum, where I do my piece and send the patient out the door, and then the primary care physician does his or her piece to help the patient, and we do this without any coordination or communication with each other," Gundersen says. "So improving coordination and communication between providers is the big thrust of what all of these discharge improvement initiatives are trying to do."

UMass has become involved in several projects to improve the discharge process, including Project BOOST, Project RED, and INTERACT (Intervention To Reduce Acute Care Transfers), Gundersen says.

"One of our goals in terms of taking different initiatives is to explore them and tweak them into something particular to UMass," she explains. "Our obvious goals are to reduce readmissions and increase patient satisfaction, and our priority is to bring better, patient-centered care to patients

## SOURCES

For more information, contact:


- **Jeff Critchfield**, MD, Associate Professor of Medicine, University of California - San Francisco; Chief, Division of Hospital Medicine, San Francisco General Hospital, San Francisco. Telephone: (415) 206-6078.
- **Elizabeth C. Gundersen**, MD, Associate Chief, Hospital Medicine, UMass Memorial Medical Center; Physician Quality Officer, UMass, 119 Belmont St., Jaquith 2, Worcester, MA 01605. Telephone: (508) 334-8515.
- **Brian Jack**, MD, Associate Professor and Vice Chair, Department of Family Medicine, Boston University School of Medicine, Boston Medical Center, Dowling 5309, IBMC Place, Boston, MA 02118. Telephone: (617) 414-5956. Email: brian.jack@bmc.org. Web site: http://www.bu.edu/fammed/projectred/.

and also to unify health care delivery systems across the community."

### References

1. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *NEJM*. 2009;360(14):1418-1428.
2. Jack BW, Chetty VK, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalization. *Ann Int Med*. 2009;150(3):178-187. ■

## Research provides ideas to improve discharges

*Nurses provide transition support*

Evidence is growing to show how specific hospital interventions at discharge can improve outcomes for patients and reduce health care costs — two goals that likely will be at the centerpiece of any new national health care legislation.

For instance, one recent study of a reengineered hospital discharge program (Project RED) found that the intervention significantly reduced hospital utilization, increased primary care physician (PCP) follow-up, and improved patient self-perceived preparation for discharge.

The study also found that the actual cost of emergency department visits totaled $21,389 for the usual care group and $11,285 for the intervention group. And actual hospital visit costs were $412,544 for the usual care group and $268,942 for the intervention group. When outpatient visits are included — which were higher for the intervention group — the total health care costs were about 34% lower for the intervention group.[1]

"Our study showed a 30% reduction in hospital utilization, including both emergency room visits and rehospitalization," says **Brian Jack**, MD, an associate professor and vice chair of the department of family medicine at Boston University School of Medicine and Boston Medical Center in Boston.

"That's very important, because in the past year, President Obama's administration has been saying they're going to pay for health care reform by changing the payment mechanisms to hospitals," Jack says. "And they have been specifically saying the 30-day rehospitalization rates will not be paid for to save $13 billion in public and private sectors to pay for health care reform."

Projects directed at improving patient safety at hospital discharge are the low-hanging fruit in reforming health care, Jack notes.

"There are 38 million discharges a year, so there are a whole lot of them and a whole lot of problems," he adds. "It's something that needs to be fixed."

The health care system from payers to providers needs to focus on improving the discharge process, and this means transforming its current culture, suggests **Jeff Critchfield**, MD, an associate professor of medicine in the department of medicine at the University of California — San Francisco. Critchfield also is chief of the division of hospital medicine at San Francisco General Hospital.

"We're trained to think about what happens in the hospital," Critchfield says. "Even though nursing as a profession has led the way by developing systems like home health care and home nursing, these systems nowhere meet the need of every patient discharged from the hospital."

Jack and Critchfield offer these examples of ways hospital discharges can be improved:

• **Support from Hospital to Home for Elders (SHHE) program:** "We've set out to develop a model that would address the relatively challenging needs of our patients at San Francisco General, which is the only trauma center in San Francisco," Critchfield explains. "We care for patients who are 35% Asian, 25% Latin American, 20% Caucasian, and 15 to 20% African-American."

Hospital-to-community transitions are particularly challenging for elderly patients who have a non-English first language, he notes.

"We wanted to put into place a system that meets their needs in a cross-cultural way," Critchfield says.

The result is the SHHE program, which includes a primary team that helps patients and their families prepare for discharge from the beginning of their hospital stay.

SHHE nurses are multicultural and multilingual, and they provide patients with support from the hospital to home.

"They meet with patients within the first day or two of their hospital stay and touch base every day patients are in the hospital," Critchfield says. "They educate them about their medications, helping them understand why they're taking these medicines, and stay in contact with the caregiving team."

SHHE nurses interact with families and commu-

nity providers to facilitate follow-up care, he adds.

They give patients written materials that are literacy-level appropriate and that clearly describe all follow-up appointments.

"We recognize that it's challenging for patients to see their primary care providers, and we think that's a really important element," Critchfield says. "Delays in seeing your doctor or nurse practitioner lead to increased readmissions."

So, patients discharged via the SHHE program are contacted by nurse practitioners (NPs), who call them on the third day and 10th day post-discharge from the hospital, Critchfield says.

The hospital also gives patients medications to take home with them, which helps to eliminate the problems of patients becoming ill because they forget or cannot fill their prescriptions immediately after discharge.

The NPs ask them these specific questions to screen for potential problems:

- Do you understand your medicines?
- How are things working out at your home?
- Do you have caregivers in your home?

If there are caregivers, the NPs speak with them, as well.

"We're experimenting with doing this by telephone, because we've decided it's too cost-prohibitive to send nurse practitioners to patients' homes," Critchfield says.

The SHHE project will be the intervention arm of a randomized, controlled trial that over a two-to-three year period enrolls about 700 patients, who speak English, Spanish, or Cantonese, and who are able to consent to the study he adds.

One goal of the program is to improve care coordination.

"One of the problems of health care is that it's so fragmented," Critchfield says. "So, the next step is to have someone coordinate and integrate the fragments, and that's what we'll have our nurse practitioners do."

Like the SHHE nurses, the nurse practitioners are multicultural and multilingual, so there are no language or cultural barriers to their interactions with patients and families.

"We see ourselves as integrators, coordinators, who bring the primary care provider into the picture," Critchfield says. "The nurse practitioners will call patients' doctors and say, 'I was on the phone with your patient today, and it sounds like they have these needs, so I'm passing this information to you and your clinic so you can start taking care of it."

- **Reengineered hospital discharge program (Project RED):**

Jack and co-investigators used patient safety techniques borrowed from engineering processes, such as nuclear power plants, and studied the discharge process to identify the principles of best practices at discharge.

Once they identified 10 items that should be a part of a reengineered discharge process, they sought funding for a study to show how it might impact the process, and this led to the clinical trial with its recently published positive results.

"We randomized patients between the usual discharge and the reengineered discharge group," Jack says. "Nurses collected the appropriate discharge information and packaged it into the hospital care plan with operationalized material we used to teach patients what to do."

Graphic designers and health literacy experts helped to develop the materials that were clear and easy-to-read visually.

One key to the discharge program's success was its emphasis on making appointments for patients for follow-up care.

"It just makes sense to have some sort of follow-up," Jack says.

### *Reference*

1. Jack BW, Chetty VK, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalization. *Ann Int Med*. 2009;150(3):178-187. ■

# Studies show decrease in senior care continuity

*End of life discussions should be reimbursed*

If the discharge planning community's ideal is to begin the discharge process at the door, when patients are admitted to the hospital, then community provider input is necessary for a smooth care transition.

But care continuity has been low, and it's decreasing for older adults, recent studies show.[1,2]

A study that examined the proportion of patients who are seen by their primary care physician during their hospitalization found a significant decline in this continuity of care, says **Gulshan Sharma**, MD, MPH, an associate professor at the University of Texas Medical Branch in Galveston, TX.

"The proportion declined from 50.5% to 44.3% between 1996 and 2006," Sharma says.[2]

The study showed an even greater decrease in continuity in cases where patients were admitted to the hospital on weekends and for those living in large metropolitan areas.[2]

The results were not too surprising given the changes that have taken place in the delivery of health care over the past two decades, Sharma notes.

"To improve efficiency of care, you have primary care physicians managing patients in very busy practices, and it's hard for them to go see patients who are hospitalized," he explains. "So there's been a large growth in hospitalists' positions, and these are the people who provide care for patients when they're hospitalized."

The older model of having one physician follow patients through the trajectory of their illness and care no longer is followed.

"The health care system is getting more efficient, with physicians spending more time at their part of this system, but the price you pay is fragmented care," Sharma notes.

"There's a lot of disruption in care, and there's no major effort to have a physician make sure the transition is smooth in either direction," Sharma says.

Similarly, there are no practice or economic incentives for hospitalists to follow up with patients once they've returned to the community, he adds.

"That's where a major discussion is going on: How do you make this transition smooth?" Sharma says. "One way would be through an electronic health record."

Hospital systems and community providers who can connect electronically can provide follow-up care and a smoother transition through electronic communication, he says.

But research suggests that having a primary care provider attend a patient in the hospital can improve health care outcomes. In one study, investigators found that patients with terminal lung cancer who were visited by community physicians while in the hospital were less likely to spend time in the intensive care unit (ICU) before death.[1]

"So it might be good for discharge planners to have a primary care physician visit patients," Sharma notes. "And discharge planning should include communication with a patient's primary care physician, so they'll know what's going on."

One reason these primary care physician visits to hospitalized patients are decreasing is that there is no reimbursement for them, Sharma says.

"Medicare won't reimburse for two physicians for the same specialty," he explains. "So, if you have an internal medicine doctor providing care and a primary care physician who also sees the patient, then whoever sends in the claim first gets paid."

Health care reform discussion has included a discussion of paying primary care providers for visiting at least terminally ill patients when they are hospitalized, but this possibility may be eliminated from any final Congressional bill because of the summer's emotional debates about insurers covering end-of-life care discussions.

Still, there has to be some discussion between hospital staff and community physicians about the patient's end-of-life care plans, whether this is via the telephone or e-mail, Sharma suggests.

"It's possible there already is some communication occurring over the phone, and our research hasn't captured that in the billing information we used from Medicare," Sharma says. "But we need a better way of reimbursing the primary care physician for helping the hospital doctor in better decision making."

Primary care physicians should be reimbursed for having these discussions with patients, he adds.

"We need to improve care transition communication and building patient-physician trust," Sharma says. "Once patients trust their physicians, they can make more appropriate decisions."

## References


1. Sharma G, Freeman J, Zhang D, et al. Continuity of care and intensive care unit use at the end of life. *Arch Intern Med*. 2009;169:81-86.

2. Sharma G, Fletcher KE, Zhang D, et al. Continuity of outpatient and inpatient care by primary care physicians for hospitalized older adults. *JAMA*. 2009;301(16):1671-1680. ■


## SOURCE

For more information, contact:


• **Gulshan Sharma**, MD, MPH, Associate Professor, University of Texas Medical Branch, Galveston, TX. Telephone: (409) 772-2436. Email: gusharma@utmb.edu.

# Challenges emerge when dealing with uninsured

*Florida case of Guatemalan man is example*

Two events made hospital discharges of uninsured, illegal immigrants a politically charged issue this past summer:

One, the backlash against proposed health care reform used the prospect of taxpayers contributing to the health care costs of illegal immigrants as a political wedge issue; and, two, a Stuart, FL, hospital became a national example of the public relations nightmare that ensues when discharge planning fails to find a solution that satisfies all parties.

Although national health care critics claimed proposed Congressional bills would cover illegal immigrants, these bills purposely omitted any discussion about care for this population and would not be of any financial help to hospitals treating illegal immigrants. However, health care systems are mandated to provide care and make an appropriate discharge to everyone who arrives through the emergency room, experts say.

Hospitals typically assume the costs of medical care for uninsured patients in the form of a bad debt write-off, and the amount of bed debt varies according to a hospital's population and location, says **Susmita Pati**, MD, MPH, senior co-director of PolicyLab and director of research programs for FOCUS at The Children's Hospital of Philadelphia. Pati also is an assistant professor of pediatrics at the Children's Hospital and the University of Pennsylvania in Philadelphia.

"In New York, California, and Texas, there are a lot of uninsured people, so hospitals in those states will have a larger proportion of bad debt than hospitals in other places," Pati says.

"Discharge planning is always a challenge for children, whether you have insurance or you don't because of issues with coordination of care," Pati says**. (See story on how children's hospitals handle discharges of the uninsured, p. 68.)**

The public rarely considers how hospitals cover the medical costs of the uninsured until there is a high-profile case like the one in Stuart, where an undocumented worker, named Luis Alberto Jimenez, was injured and needed emergency medical care that was not reimbursed by any governmental or private insurer.

The Emergency Medical Treatment and Active Labor Act (EMTALA), passed by the U.S. Congress in 1986, requires all hospitals receiving Medicare or Medicaid funding to provide an appropriate medical screening and stabilizing medical treatment to anyone who comes through their doors needing emergency treatment, says **Eve Green Koopersmith**, Esq, a partner and chair of the discharge planning, patient rights, and elder law practice group at Garfunkel, Wild & Travis in Great Neck, NY.

Hospitals must provide emergency medical care and, if necessary to stabilize an emergency medical condition, admission to the hospital, regardless of patients' ability to pay, and this includes care to undocumented workers, who are not eligible for federally funded medical reimbursement, she adds.

However, if uninsured, undocumented patients require nursing or therapy treatment in a post-acute setting, there is no funding or mandate for that to occur.

"So, there's the conundrum," Koopersmith says. "If you have a patient who requires skilled services, it's difficult to establish a discharge plan for that person if there is no funding."

The U.S. is not alone in mandating emergency care.

"Almost every country is like the United States and provides emergency care to everyone, because you can't just let people die," says **James Dwyer**, PhD, an associate professor in the Center for Bioethics and Humanities at SUNY Upstate Medical University in Syracuse, NY.

"We're different from other countries, because for immigrants — both legal and illegal — we haven't been as good at providing primary care and rehabilitation after they leave the hospital," Dwyer says. "I think other societies have done more."

The debate is over what, if anything, this society owes to people who are in this country illegally, he adds.

"That's the hard issue," Dwyer says. "I believe that as a society we owe people who are working here — even if we have a right to keep them out — primary care and a reasonable amount of rehabilitation."

However, it's a different debate when the question is whether a particular hospital owes an uninsured, illegal immigrant post-acute, post-emergency care.

"We're sort of stuck here where hospitals can't do it all, and there has to be more community

solutions to this problem," Dwyer says. "But hospitals do have a role to play in this, and it's not just in caring for patients, but also in being proactive and trying to get community and national solutions in place."

The Jimenez civil lawsuit against Martin Memorial Medical Center of Stuart highlighted this dilemma.

Officials from Martin Memorial Medical Center declined to be interviewed for this story due to the possibility of a legal appeal in the case.

The issue raises ethical and health care payer questions for the United States, but it also suggests that hospitals need to have a plan for how to effectively and safely discharge patients when there are no volunteers to take them in.

"Hospitals and emergency rooms have no alternative but to treat patients who have no ability to pay in emergency situations, but there is no requirement for long-term care service providers," says **Linda S. Quick**, president of the South Florida Hospital & Healthcare Association of Hollywood, FL.

"And hospitals are ill-suited to become residential facilities, and that's how we get into these problems in the first place," Quick says. "One thing institutions are going to have to do a better job of is having communications with patients and families, literally from day one, about what is realistic in the way of expectations they can have."

U.S. hospitals, particularly Florida health systems and hospitals bordering Mexico, have dealt with the ethical and financial consequences of providing emergency care to uninsured illegal immigrants for years, Dwyer says.

"It's hard to get good data, but there are reports suggesting that [discharging illegal immigrant patients to other countries] is a pretty widespread practice," Dwyer says. "Consulates get phone calls from hospitals trying to arrange these deportations, and some hospitals have admitted to deporting between seven and 100 patients a year."

About 85% to 90% of the patients and families accept the transfer, he notes.

U.S. hospitals commonly make arrangements with immigrants' families, both in the U.S. and outside this country, Koopersmith says.

"When I'm consulted on these issues, it's always a discharge arranged with consent with the patient or, if the patient doesn't have the mental capacity to make decisions, with the patient's family," she explains.

"Hospitals are coming up with discharge plans and trying to be creative in providing ongoing services for patients," Koopersmith says.

For uninsured, undocumented immigrants who need long-term nursing care, there are few options in the United States, because Medicaid does not cover these patients, and few facilities will care for these patients as charity cases, experts say.

The state of New York provides more funding options by expanding Medicaid coverage to some noncitizens, and some cities might have immigrant groups who will offer some form of assistance, Koopersmith notes.

Even American citizens who have no insurance and who have lived in the United States for less than five years could face this problem, because public assistance isn't available to them, Dwyer says.[1]

"The problem is the health care system doesn't have long-term care services for unfunded patients," Quick says. "I don't envy discharge planners their efforts to find alternatives."

### Reference

1. Dwyer J. When the discharge plan is deportation. Hospitals, immigrants, and social responsibility. *Bioethics*. 2009;23(3):ii-iv. ■

# Discharge often difficult at children's hospitals

*Too few post-acute pediatric options exist*

A researcher and pediatric physician who has studied insurance and immigration issues related to medical care has found that several myths create an emotional response that complicates the medical and political issue of who should pay for health care for undocumented immigrants.

For example, the average costs of medical care for immigrant children is considerably less than the cost of medical care for children who are not immigrants, says **Susmita Pati**, MD, MPH, senior co-director of the Children's Hospital of Philadelphia (CHOP) and director of research programs for FOCUS, which is a program supported by the Dean of the University of Pennsylvania's School of Medicine.

Pati also is an assistant professor of pediatrics at CHOP and the University of Pennsylvania in

## SOURCES

For more information, contact:

- **James Dwyer**, PhD, Associate Professor, Center for Bioethics and Humanities, SUNY Upstate Medical University, 618 Irving Ave., Syracuse, NY 13210. Telephone: (315) 464-8455. Email: dwyerja@upstate.edu.
- **Eve Green Koopersmith**, Esq., Partner, Chair, Discharge Planning, Patient Rights and Elder Law Practice Group, Garfunkel, Wild & Travis, 111 Great Neck Road, Suite 503, Great Neck, NY 11021. Telephone: (516) 393-2200.
- **George Ochoa**, Owner, Partner, MexCare, 2220 Otay Lakes Road, Suite 502, Chula Vista, CA 91915-1009. Telephone: (760) 839-2370. Email: gochoa@mexcare.com. Web site: www.mexcare.com.
- **Susmita Pati**, MD, MPH, Senior Co-Director, PolicyLab; Director of Research Programs, FOCUS; The Children's Hospital of Pennsylvania; Assistant Professor of Pediatrics, University of Pennsylvania, 34th & Civic Center Blvd., Philadelphia, PA 19104. Telephone: (267) 426-5056. Email: pati@email.chop.edu
- **Linda S. Quick**, President, South Florida Hospital & Healthcare Association, 6363 Taft St., Suite 200, Hollywood, FL 33021. Telephone: (954) 964-1660. Email: lquick@sfhha.com.

Philadelphia.

Pati's research has shown that what is spent on health care for an immigrant child is one-third as much as the average spent on children who are not immigrants.[1]

And immigrant children are far less likely to be insured, particularly through public health insurance, since immigration reform in the late 1990s.[2]

"The prevailing misconception in the general populace is that immigrants are draining our health care system because they don't have insurance and that it costs more to take care of them," Pati says.

"Another myth is that tons of immigrants are on public insurance rolls, and the study I published shows that also is not true," Pati says. "Immigrant kids are much more likely to be without coverage."

However, discharge planning for hospitalized children is challenging regardless of the child's insurance or immigration status, she notes.

"We might have trouble finding an appropriate home care provider when children need antibiotics via IV or if they need additional therapy for a head injury in an accident," Pati explains.

There are too few long-term care or rehabilitation facilities for children, she says.

"It's a chronic problem, and for children who have mental health needs, inpatient psychiatric facilities are incredibly lacking, as is reimbursement for those types of services," Pati says.

"Some things are easier to arrange than others," she adds. "But in general, long-term types of care like rehabilitation are very poorly reimbursed when compared with antibiotic administration, and those are inherent challenges we have in the system."

At CHOP, there is a dedicated group of people who work to find coverage for children who don't have it, Pati says.

"When a family doesn't have insurance coverage, they work with the family to apply for whatever they might be eligible for or to arrange for a payment plan or for charity care," she says. "Those are the three options."

Many hospitals do not provide this service, Pati notes.

"Unfortunately, there are cases where no post-hospital care can be worked out very quickly, and children sometimes stay in the hospital a few extra days," she adds. "But that's obviously not ideal for anybody."

This is one of the situations where hospitals and discharge planners cannot fix the problem through their own individual efforts.

"Almost no solution can be handled singly by providers," Pati says. "We need public policy changes."

Children can languish in the hospital while medical providers cope with finding an appropriate skilled facility, ensuring post-acute medical care will be covered, and communicating with families who often do not speak English as their primary language, Pati explains.

"There are plenty of cultural and ethnic community-based organizations you can tap into as resources," she notes. "But if you talk about a child who needs long-term rehabilitation, they're not able to do that; they can provide someone with a ride to a grocery store, but they can't give a child physical therapy."

American society would benefit as a whole if leaders would address and resolve this problem,

Pati says.

"I don't know what will happen in this current political environment," she says. "The American public understands the problem with health care coverage, but the debate gets hijacked, and people lose sight of the larger picture."

Ideally, there should be no child living in this country without high-quality, affordable, and comprehensive health care coverage, Pati says.

"Children are where an ounce of prevention is worth a pound of cure, and if we don't invest in children from birth to three years of age, we end up paying for it many times over," she adds.

### Reference


1. Mohanty SA, Woolhandler S, Himmelstein DU, et al. Health care expenditures of immigrants in the United States: a nationally representative analysis. *Am J Pub Health*. 2005;95(8):1431-1438.

2. Pati S, Danagoulian S. Immigrant children's reliance on public health insurance in the wake of immigration reform. *Am J Pub Health*. 2008;98(11):2004-2010. ■


# Hospital created simple, effective discharge tool

*Nurses helped create it*

An effective and simple discharge checklist is the ideal tool for hospital nurses and others who handle the patient discharge process.

The University of New Mexico Hospital in Albuquerque, NM, has developed one that meets both of these goals and has received high marks from nurses who use it.

The hospital developed the tool after becoming involved in Project BOOST (Better Outcomes for Older adults through Safe Transitions), which is sponsored by the Society of Hospital Medicine in Philadelphia, PA.

"One of the things we've had some success with is our discharge checklist for nurses," says **Percy Pentecost**, MD, assistant professor of medicine at the University of New Mexico Hospital.

"What we found is there is not a lot of consistency in the way discharges were done, so we

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

## CNE *questions*

9. A recent study of Medicare beneficiaries found that one-fifth who were discharged from the hospital were rehospitalized within 30 days. What percentage of patients with medical conditions were rehospitalized or died within the first year after discharge?
   A. 32%
   B. 49%
   C. 53%
   D. 67%

10. In a discharge program that provides follow-up phone calls to patients who returned home, which of the following would be a good question for a nurse or nurse practitioner to ask patients?
   A. Do you understand your medicines?
   B. How are things working out at your home?
   C. Do you have caregivers in your home?
   D. All of the above

11. A study of the reengineered hospital discharge program (Project RED) found that actual total hospital visit costs were $268,942 for the intervention group. How much were they for the usual care group?
   A. $115,898
   B. $292,884
   C. $412,544
   D. $512,379

12. TRUE or FALSE: Hospital discharge planning for children is particularly difficult because there are too few long-term care, mental health inpatient facilities, or rehabilitation facilities for children.
   A. True
   B. False

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

tried to make that more consistent," he explains. "The way we've done that is to come up with a discharge checklist that all the nurses on our trial floor utilize every time they discharge a patient."

For example, if a patient has his prescriptions in hand or has a way to obtain his or her prescriptions before arriving home, this will improve the patient's discharge process.

"If you hand somebody prescriptions at 8 p.m., it doesn't do them any good because the pharmacies are all closed," Pentecost says. "So we're trying to anticipate the details needed for discharge."

Another example of a discharge detail involves making certain patients understand and can repeat back all of the warning signs of problems.

"So if they're admitted with pneumonia, they should be able to articulate to the nurse before the discharge that they know to call their medical provider or return to the emergency room if their breathing gets more difficult or if they develop a cough or fever," Pentecost says.

"The checklist is implemented on our trial floor, and the nurses are quite pleased with it, and they feel it adds consistency and helps them organize their thoughts," he adds.

The hospital's nurses helped develop content for the discharge checklist, which consists of one page. **(See discharge checklist, p. 72.)**

"The nurses wanted to keep the checklist to one page," Pentecost says. "In fact, we gave them our trial version of four things, and they're the ones who said, 'That's a good start, but we also need this and this and this.'"

Based on that positive beginning, the checklist was revised and improved.

"The tool has helped us develop some unity and purpose in trying to improve discharges," Pentecost says.

The hospital plans to share its checklist with other hospitals through Project Boost, and Pentecost already has discussed it with peers in Project BOOST conference calls.

Project BOOST on its Web site already has a toolkit that includes a discharge checklist that has been used successfully by other hospitals, Pentecost notes. ■

### SOURCES

For more information, contact:

• **Percy Pentecost**, MD, Assistant Professor of Medicine, University of New Mexico Hospital, Albuquerque, NM 87131. Telephone: (505) 272-2147. Email: PPentecost@salud.unm.edu.

## 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

- Minimize LOS with interdisciplinary collaboration
- SAFE DC helps homeless inpatients with discharge
- Heart failure patients too often not discharged with best medication, study shows
- Check out this new discharge planning tool

# Here's a look at UNM Hospitals discharge checklist

**University of New Mexico Hospitals 4 West Discharge Checklist Pilot**

***Nurses, please review checklist at the bedside with patient or caregiver. Coordinate with other disciplines as needed.***

___ Correct phone number on facesheet/Powerchart is _____.
___ Has transportation to their destination.
___ Patient or caregiver is ready to assume responsibility for patient's care.
___ Durable equipment received prior to going home (home O2, VAC supplies).
___ Can describe major warning signs & symptoms and what to do if they occur.
___ Has a way to obtain and start taking home medications on time.

***High Risk Medications (Coumadin, Digoxin, Aspirin & Plavix combo, Lovenox, Arixtra, Insulin)***
___ Has high risk med handouts printed from Micromedex.
___ Watched teaching videos (Coumadin, Arixtra).
___ Return demo of injectable medications witnessed (Lovenox, Arixtra, Insulin).
___ Understands above meds are high risk and can name major problems and what to do.
___ Knows date and time of follow up appts and can locate on Discharge Summary.
___ Can locate medical team written at top of Discharge Summary and knows to contact the 4W Charge RN to contact their team.
___ Prescriptions given, or transfer orders and packet prepared for SNF/rehab.
___ Medication reconciliation is correct and signed by physician, RN and patient. Reviewed with patient. Retain signed copy for chart.
___ Belongings list signed by patient (copy to patient and to chart).
___ Discharge Summary complete, stamped by HUC, signed by charge RN, yellow copy to patient must be legible (otherwise provide photocopy).

I have received my prescriptions, discharge summary, medication list, and belonging list. A nurse has completed this checklist with me.

Patient: _____ Nurse:

_____ Date/Time: _____

• **Note:** *This one-page discharge checklist is reprinted with permission from Percy Pentecost, MD, Assistant Professor of Medicine, University of New Mexico Hospital in Albuquerque, NM.*





# Study: ICU used more by dying in U.S. than in England

A new study shows that patients with terminal illness are significantly more likely to be treated in intensive care units in the United States than they are in England.

The study, published in October, 2009, in the *American Journal of Respiratory and Critical Care Medicine*, found in a retrospective cohort study of the year 2001 that only 5.1% of all deaths in England involved intensive care, while 17.2% of all deaths in the United States involved intensive care. ■

DISCHARGE PLANNING
ADVISOR

# *2009 Index*

*When looking for information on a specific topic, back issues of* Discharge Planning Advisor *newsletter, published by AHC Media LLC, may be useful. For additional information, contact our customer service department at P.O. Box 740060, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291 or (404) 262-7837. E-mail: customerservice@ahcmedia.com.*

**Best practices**
Children's hospital's improved DP process yields tangible benefits, JUL/AUG:37
Discharge checklist is simple, effective tool, NOV/DEC:70
Health care services are becoming more integrated, MAR/APR:16
Here's a look at discharge checklist tool, NOV/DEC:72
How one hospital made its DP more efficient, JUL/AUG:40
New strategy helps with discharging preemies, JUL/AUG:48

**Centers for Medicare and Medicaid Services**
Hospital-acquired conditions explained by CMS, JAN/FEB:12
Know CB requirements when referring to PA care, MAR/APR:24
Know nuts & bolts of CMS Condition Codes 42,43, JAN/FEB:12

**Discharge summary**
Improve your discharge summary with this advice, JUL/AUG:46
Study: deficits in discharge docs of transferred patients, JAN/FEB:10

**Discharge support**
Discharge planners and home care staff need to improve communication, JAN/FEB:1
NTOC has patient medicine list online, MAR/APR:17
Researchers study transition to community successes, MAY/JUN:35

**Diversity issues**
For the best outcomes, consider patient's culture, SEP/OCT: 55
Tips for teaching patients with low health literacy, JAN/FEB:9
Uninsured, undocumented patients present complicated challenges at discharge, NOV/DEC:67

**Electronic health records**
Australian system relies on e-discharge summary, MAY/JUN:28
Electronic health records are changing discharge planning in unexpected ways, MAY/JUN:25
Hospitals can redesign care processes using HER, JUL/AUG:41
System integrates physician sign-out process with EMR, JUL/AUG:43

**Improving resource utilization, efficiency**
Expert offers tips on improving DP flow, MAY/JUN:31
Extra diagnostic testing can cost hospitals big, SEP/OCT:60
Hospital discharge process can be more efficient, MAY/JUN:29
Research shows decrease in care continuity among older adults, NOV/DEC:65

**Miscellaneous**
AHA survey reports bad economic news for hospitals, JUL/AUG:48
Children hospital discharges are always complicated, NOV/DEC:68
DPs need to communicate with families about APS, MAY/JUN:33
Economic pressures increasing for patients, MAR/APR:17
New CM adherence guidelines expected soon, JAN/FEB:7
Reduce one-day stays when observation is better, SEP/OCT:58
Sometimes DP has no great options, SEP/OCT:57

**Quality improvement**
Hospital, community organization's DP model, MAR/APR:21
Improving discharge without high costs? Try a CBO, MAR/APR:19
Improving hospital discharge process is project tackled through variety of plans, NOV/DEC:61
Research projects show how to improve the discharge process, NOV/DEC:64
Scale measures quality of hospital discharge process, MAY/JUN:32

**Re-engineering discharge process**
Hospital's discharge process was improved, SEP/OCT:53
Project BOOST has produced early, positive results for involved hospitals, SEP/OCT:49
Project BOOST's evolution has led to DP changes, SEP/OCT:52

**Safety issues**
Avoid problem areas in striving for safe transitions, JUL/AUG:44

**Transition solutions**
How to prevent crises during transitions in care, JAN/FEB:3
Improving referrals to post-acute care, JAN/FEB:6
Too few chronic patients referred to post-acute care, JAN/FEB:5
Transitions in care plans should include strong DP support, MAR/APR:13

DISCHARGE PLANNING
ADVISOR

**DPA120109TM**

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.

Account # _____
Name: _____
Company: _____
Address: _____
City: _____
State: _____
Zip _____
Fax: _____
Phone: _____
E-mail: _____

**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)*** _____